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sexual health

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Is HIV treatment fairly distributed in Malawi?

Malawi extended its free HIV drug treatment through its public health service to reach 17,000 patients by March 2005. But who is getting treatment? Is drug distribution fair? Research by the Ministry of Health shows steady progress but a need to improve access for children, pregnant women and patients with tuberculosis (TB).

An estimated 900,000 adults and children in Malawi are living with HIV and AIDS. Up to 170,000 need anti-retroviral therapy (ART) immediately. By January 2005, 34 public health facilities were delivering ART free of charge, using the first line combination of stavudine, lamivudine and nevirapine. But there are worries that users may not be representative of the population in need of treatment. To study this, researchers looked at patient cards and registers for patients who started on ART in the last three months of 2004 (3,261 patients) and the first three months of 2005 (4,530 patients). They found that of these:

- About 40 percent are male.
- Some 95 percent are at least 13 years old.
- The women are in general 10 years younger than the men.
- Up to 90 percent started ART because of a clinical assessment of World Health Organization stages III or IV of HIV disease; the rest due to a low CD4 cell counts.
- Eleven to 15 percent have TB.
- Only 29 pregnant women were part of programmes to prevent mother-to-child transmission of HIV.
- Around 56 to 62 percent are subsistence farmers, housewives or in small-scale businesses such as being a market vendor or selling fish.
- Six percent and four percent of patients, respectively, are teachers and health care workers.

These results show that the characteristics of patients receiving ART reflect those of adults with HIV in terms of gender, age and occupation. However, 10 to 15 percent rather than five percent should be children and many more pregnant women require ART. In addition, only 1,053 of the predicted 10,000 TB patients who needed ART joined the programme in this six month period. The rural population may also be underserved. Improving access for these groups requires:

- new technical recommendations to simplify the diagnosis and management of HIV in children, especially infants
- more user-friendly paediatric drug formulations
- prioritising the limited number of free CD4 tests for patients in stage II or pregnant women in stage I of HIV
- better access to HIV testing for TB patients
- addressing drug interaction between TB and HIV treatments
- resolving the tension between delivery of ART largely through hospitals and of TB treatment through health centres.

Anthony Harries
Family Health International, Malawi Country Office, Arwa House, 3rd Floor, PO Box 30455, Lilongwe 3, Malawi
F +265 1 774 307 **adharries@malawi.net**

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Caring for AIDS patients at home in Malawi

Home-based care is crucial for people with AIDS, yet it is not often available for patients in African countries. As AIDS patients experience different health problems, it is important to develop an understanding of the occurrence and duration of common illnesses in order to determine the needs of the patient community.

The World Health Organization (WHO) and UNAIDS advocate home-based care for people living with AIDS as an important part of the health response to the disease. In Malawi, the Bangwe home-based care project is run jointly by the Salvation Army and the College of Medicine and provides a service to the township's population of 40,000 people. Since January 2003, data has been collected on patients' health problems as well as how they respond to treatment and their nutritional status. During the course of the study, antiretroviral drugs became available free of charge.

A study by the College of Medicine looks at patient mortality, frequency of diseases, how severe the symptoms are, recurrence rates, duration of the symptoms and whether or not patients' needs were met, measured over 18 months. The mortality rate was high: 199 of the 358 patients studied died during this period, a third of them within four months of first assessment.

The study makes the following findings:

- Patients' needs are high, with many of them already experiencing multiple symptoms at enrolment and some of the symptoms recurring.
- While some patients die shortly after first being seen, many survive and require long-term clinical and palliative care.
- Substantial pain is common among these patients, with 84 percent reporting medium to severe pain at their first assessment.
- Basic treatment of opportunistic infections seems to be successful for most symptoms.
- Some patients need an opioid or codeine phosphate for pain but these are expensive and often not available. Morphine has limited success in Bangwe as it is difficult to administer.

There is a greater need for home-based care in Malawi. Only about half of patients with chronic illness sought help from the home-based care team, thus better community volunteers are needed to improve coverage. The study makes the following recommendations:

- Because of the difficulty in using morphine in Bangwe, an alternative would be a morphine modified release preparation (MST), when a cheap version is available.
- As most symptoms occur for about two weeks at a time, the supply of prescribed drugs needs to last for this period.
- Patients needing palliative care and those with severe infections need ongoing weekly visits until the symptoms have cleared up.
- After treatment, repeat episodes tend to be shorter in duration. As recurrences occur in some patients, it is vital that community volunteers are able to identify these patients.
- Food supplementation does not seem to improve patients' survival rate, nutritional status or symptoms, therefore other needs such as income relief may be more appropriate.

Cameron Bowie
Department of Community Health, College of Medicine, Private Bag 360, Chichiri, Blantyre 3, Blantyre, Malawi
T +265 167 1911 **F** +265 161 72535
cam.bowie@malawi.net

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Antiretrovirals offer good value for South Africa

South Africa's HIV epidemic has enormous social and economic consequences. Providing hospital care for HIV patients is very expensive for the health system and costs are expected to rise. HIV accounts for 24 percent of all hospital admissions and 12.5 percent of the total public health budget.

Highly Active Anti-Retroviral Therapy (HAART) has been shown to be cost-effective in reducing deaths and sickness from HIV in developed countries. It has enabled many people with HIV to be treated on an outpatient basis, avoiding the need for hospital admission.

Until recently it was thought that the South African government was unable to afford to provide HAART. However, the costs of the anti-retroviral (ART) drugs for developing countries have been reduced in recent years and the South African government has announced a commitment to providing ART through the public health service. The government has awarded contracts to international companies to supply the drugs to health facilities throughout the country. These contracts are anticipated to drive down the price of ART further.

Researchers assessed the cost-effectiveness of HAART for the South African health service, by comparing the use and costs of HIV-related health services by people who were receiving HAART with that of patients who were not receiving ART (the control group). Two scenarios for HAART prices were used: scenario one used current South African public sector ART drug prices of US$ 730 per patient year (PPY), whereas scenario two was based on the anticipated public sector price for locally manufactured drugs of US$ 181 PPY. The study was conducted in Cape Town between January 1995 and December 2000 with 265 HIV-infected adults and 27 with AIDS (HIV stage four) in each group.

The following findings were reported:

- The disease progressed more slowly in the HAART group than in the control group.
- HAART patients had significantly fewer inpatient days than those not receiving ART, but had significantly more outpatient days.
- The average cost PPY of inpatient services for patients in the HAART group was significantly less than for the control group, while the corresponding average cost of outpatient visits PPY was not significant.
- Treatment with HAART for people with AIDS was cheaper for both price scenarios.
- For patients with HIV but not AIDS, HAART was cheaper under the second price scenario.
- For both ART and non-ART groups, use of inpatient services increased with increased severity of the infection.

The study shows that HAART slows disease progression and reduces dependence on inpatient services, resulting in significant health benefits and cost reductions.

Policy implications include:

- The costs under the two price scenarios show that introducing HAART would be highly cost-effective in Cape Town.
- The study included only the direct costs of treatment, and not the indirect cost of illness. If indirect costs, such as lost workdays or quality of life, were included in the analysis, HAART would prove to be even more cost-effective.
- In addition to the benefits for HIV patients, a national HAART programme would reduce HIV-related demand for hospital services. This would generate savings on expenditure and/or release resources for use elsewhere in the health system.

Motasim Badri
Department of Medicine, Desmond Tutu HIV Centre, University of Cape Town, Cape Town, South Africa
T +27 21 6506957 **F** +27 21 6506963
motasim.badri@hiv-research.org.za

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Integrating family planning and sexual health in South Africa

Maternal and child health and family planning clinics are often a woman's only contact with a health system. South Africa is ahead of most African countries in integrating sexual and reproductive health services into its wider health system. What lessons can it offer other countries?

A study conducted in 2001 by the University of KwaZulu-Natal, South Africa and the London School of Hygiene and Tropical Medicine, UK, aimed to explore the realities and obstacles faced by clinics offering integrated health care in KwaZulu Natal province.

Integration aims to bring previously separate sexual and reproductive health services into a single structure so that patients can be offered a comprehensive range of services. The need for this is underlined by the national HIV survey findings that almost 33 percent of women attending antenatal clinics in KwaZulu Natal were HIV positive at the time of the study.

Researchers interviewed 40 staff and 300 patients at eight government health facilities to find out if patients were offered sexual and reproductive health assessments in addition to having their main complaint attended to. Patients were also asked whether they would welcome integrated services. The patients group included 100 family planning (FP) clients, 100 clients of maternal and child health (MCH) services and 100 clients of sexually transmitted infection (STI) services. Of the patients, 81 percent were female, 84 percent were aged less than 30 and 73 percent were neither married nor co-habiting.

Most health workers were positive about integration preventing duplication of services and ensuring confidentiality, but expressed two main obstacles to implementation:

- Long queues mean staff can only address the initial problems clients present with.
- Many providers have specialist training in FP services, but not in managing or diagnosing sexual health problems.

As a consequence most opportunities for offering an integrated service were missed:

- Only a small number of clients were assessed for conditions other than those they presented with. Most would welcome more assessments and advice.
- When FP and MCH clients were asked to rate their risk of HIV infection. Thirty percent rated their risk level as medium or high, yet had been given no advice or information about HIV or other STIs.

For integration to work, changes are needed in how clinics are run:

- Priority needs to be given to training staff in STIs (especially HIV) as well as family planning and maternal health.
- General information needs to be given to patients regarding reproductive and sexual health.
- The administrative workload on health care providers needs reducing to increase the time they can spend with clients.
- Clients could be screened by aides or booking clerks to identify in advance needs for advice in addition to their main complaint or need.
- Clinics could make greater use of lay counsellors to find out and discuss sexual health concerns and reduce waiting.

Pranitha Maharaj
School of Development Studies, University of KwaZulu-Natal, Durban, 4041, South Africa
T +27 31 2602243 **F** +27 31 2602359
maharajp7@ukzn.ac.za

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id21
Institute of Development Studies
University of Sussex
Brighton, BN1 9RE UK

T +44 (0) 1273 678787
F +44 (0) 1273 877335
E id21@ids.ac.uk

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