

THINGS TO THINK ABOUT

Well, the national antiretroviral roll-out is rolling – and we're hearing about activity in just about every province, which is very good news indeed. This journal should be a barometer for how things are going, and perhaps we will undertake to devote half a page or so to monitor progress right across the country. Also we welcome papers on lessons learnt, successes and difficulties from all parts of South Africa – as we share our experiences we will improve our services and make more of an impact.

I know in the Western Cape our AIDS Directorate is very pleased with how things are going, with numbers in current sites increasing weekly and more sites being added monthly. The challenge as initial roll-out takes place is to think one step ahead and anticipate the problems of the future. Just three such problems immediately come to mind, though there are many more to think about and plan for.

The first is recognition that most of the resources are being put into outpatient care. This makes sense when we need to treat many thousands of people, as in our national tuberculosis programme. However, a truly comprehensive health service must offer primary, secondary and tertiary care. While we are treating the sickest of the sick, which will continue for some time as the criteria for starting antiretroviral therapy are AIDS or a markedly reduced CD4 count, we can expect fairly significant mortality and morbidity in the early days of therapy. Aggressive and expert inpatient care for recognition and treatment of the immune reconstitution syndromes, including difficult-to-diagnose TB (often requiring diagnostics not available at primary or even secondary levels), and other opportunistic infections, will enable more people to make it through those troublesome first three months and then have as good a stab as anyone at longer and better lives. And don't forget the small proportion of really adherent patients who develop late side-effects that may need an effective multi-specialist approach to get these 'excellent' patients back to their busy lives.

The other area we are going to have to address as ARV programmes mature is the fact that a large proportion of our patients (70% at Hanan-CRUSAID in Gugulethu) is female and that as viral loads are suppressed and young people begin to feel better, issues around sexuality, fertility and reproduction are raised. A female star on 'Isidingo' has in recent episodes been grappling with just these issues while living with HIV infection. As a health profession we are going to have to work through this one and formulate some appropriate responses. Of course people have a right to children, and I don't think we will be able to decide otherwise! The first prize will be to work with

our patients and ensure that they understand all benefits and all risks and make their decisions with cool heads and with full knowledge. A challenge in a busy ARV clinic! Again, I don't think we are going to be able to have enough doctor and nurse time for these important discussions, so we will need to equip our therapeutic counsellors, foot soldiers, treatment buddies or peer counsellors with the relevant facts so that we get the right messages out there.

What an exciting time to be a health practitioner! HIV and the provision of ART have really brought to the fore patient autonomy and the need for a proper and equal patient-practitioner relationship. A challenge for many of us who haven't experienced this before, but oh! so refreshing!

Finally, Andrew Boule and Helen Meintjies highlighted a very important third issue to think about as a consequence of the AIDS epidemic and treatment in the 27 August edition of *Mail and Guardian*. They remind us that we have the largest HIV epidemic in the world and will soon have the largest ART programme too. The foster care grant (R530 per month) and the disability grant (R740) have the fastest increase in uptake, and this is a direct consequence of the HIV epidemic. Although not intended to do so, in the absence of adequate social security alternatives each of these grants currently plays a critical role in alleviating poverty in households throughout South Africa. Yet, as Boule and Meintjies point out, it is discriminatory to provide grants to orphans to the age of 18 years without providing at least equal support to the many other impoverished children whose parents are alive. The child care grant (R170) is of much lower monetary value and only eligible to the age of 11 years. Until the introduction of a national ARV programme where hopefully all eligible HIV-infected persons will be treated with ART, a disability grant awarded to a person with advanced HIV disease was effectively a 'grant for life'. Patients on ART will not sicken to the same extent and therefore never be eligible for the grant, or else may improve significantly, leading to grant withdrawal. In communities where the low employment rate is more of an obstacle to gainful employment than the HIV epidemic, this may have dire effects on the family and indeed on allowing the individual to remain in care. People may delay testing and enrolment in care until they qualify for a disability grant, and then not have the incentive to adhere to therapy once on treatment. Boule and Meintjies conclude that a possible solution is extension of the child support grant to all children up to 18 years and the implementation of a basic income grant. They argue that it is only with such comprehensive social security that South Africans will be equitably supported through the HIV epidemic.

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