

## Editorial

# Universal access to HIV care: pitfalls and the way forward

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In the July issue of TMIH, Posse *et al.* (2008) reviewed barriers to access to HIV treatment. The most frequently cited barriers are lack of information about and perceived high cost of antiretroviral treatment (ART); stigma; non-availability of treatment over a long period of time; lack of coordination across services; and long distances from home to hospital. To overcome these barriers, they suggest enhanced dissemination of information about HIV/AIDS and related care; fee waivers; health insurance; integrating services within the health system; and assurance of ART stock availability. Their review reveals the limited amount of research on barriers to ART delivery.

An important issue that is not discussed in their paper is the access to HIV testing and its link to HIV care. Many patients in resource-limited settings present for HIV care late in the course of HIV disease (WHO Stages 3 and 4), leading to a high mortality within the first 3 months of ART (higher than in industrialised countries) (Jerene *et al.* 2006; Stringer *et al.* 2006). Figures on mortality rates and causes of death for people living with HIV in resource-limited settings are scarce (Braitstein *et al.* 2006). Even less is known about the number and characteristics of people who are eligible for ART but die before being able to start it, since on-treatment analyses on mortality do not include patients falling into the gap between diagnosis and treatment (Yu *et al.* 2007).

One way forward to improve access to HIV care in resource-limited settings is to increase Provider-Initiated HIV Testing and Counselling and to use existing health facilities such as emergency units, Prevention of Mother-to-Child Transmission, Antenatal Care, Sexually Transmitted Infection clinics and Tuberculosis programmes as entry points for HIV testing, treatment and care.

### Provider-initiated HIV testing and alternative entry points

According to UNAIDS, only 10% of HIV-infected individuals worldwide are aware of their HIV status (Cohen

2007), and traditional Voluntary Counselling and Testing systems have many limitations (Yu *et al.* 2007). In Malawi, the majority of clients attended voluntary counselling and testing because they perceive themselves to be at risk of HIV infection. Thus, the large group of people who do not perceive themselves to be at risk may be left out (Jereni & Muula 2008). In the emergency unit of a referral hospital in Uganda, 83% of the patients were unaware of their HIV serostatus, although 88% of them had been to a health unit in the previous 6 months (Nakanjako *et al.* 2007a). Fifty per cent of the patients tested were HIV positive (Nakanjako *et al.* 2007a,b). In an emergency department-based HIV testing programme in western Kenya, 97.7% of patients accepted routine HIV testing, of whom 22.7% were HIV positive (Waxman *et al.* 2007).

In 2004, the antenatal care and maternity unit of a hospital in rural Uganda introduced routine opt-out intra-partum HIV testing for women and accompanying men. Acceptance was 86–98% and the programme increased the detection of HIV by 12% and the percentage of women discharged from the maternity ward with documented HIV status by 49% (Homsy *et al.* 2006). A routine antenatal HIV testing programme in Zimbabwe identified far more HIV-positive pregnant women and induced more follow-up of mother/infant pairs at ART clinics than voluntary counselling and testing (Chandisarewa *et al.* 2007). The Prevention of Mother-to-Child Transmission-Plus Initiative demonstrated a prolonged benefit of access to ART for pregnant women and their families (Tonwe-Gold *et al.* 2007). A review of national programme data for 2004–2005 from resource-limited settings indicated that 28% of women who received ART for Prevention of Mother-to-Child Transmission also received it for their own health (Luo *et al.* 2007).

These promising results indicate the need to move from pilot projects to an integrated approach, through universal implementation of the WHO guideline for provider-initiated HIV testing, which recommends testing for all patients attending health facilities in generalized HIV epidemics (WHO 2008).

### How to close the gap between a positive HIV test and follow-up care?

Most countries have established a free-of-charge system, but transport costs remain a major barrier to return for clinic visits (CDC 2004; Posse *et al.* 2008). The high pre-treatment mortality in resource-limited settings indicates an inappropriate lag between HIV diagnosis and initiation of treatment (Lawn *et al.* 2005).

Both elements suggest the necessity to bring CD4 count testing and ART delivery closer to HIV testing sites to facilitate timely identification of patients eligible for ART and to reduce the number of people lost to follow-up after a positive HIV test. More research is required on the numbers and characteristics of people at risk of dying while awaiting ART, to identify a target population for expedited ART initiation. Moreover, we urgently need to improve access to CD4 count testing and to ART for hospitalised patients to lower the high HIV-related mortality (9.7–26.3%) among inpatients as well as pre-treatment mortality in general (Sobhani *et al.* 2007.)

### Improving access to quality HIV care

Even if ART is available, major obstacles to provide optimal care remain. Deficiencies in human and financial resources strongly limit the scale-up of HIV/AIDS care in health systems that are already struggling with a shortage of qualified health staff (Van Damme *et al.* 2006; MSF 2007). Due to poor working conditions, low pay, the risk of occupational transmission and the stress of working in communities devastated by HIV, the shortage of health workers is critical in 57 countries, mostly in sub-Saharan Africa (ILO 2004). To counteract this crisis, WHO launched the ‘Treat, Train, Retain’ plan that aims to prevent HIV infection among health workers, to treat those who are infected, to expand the workforce by training new people and to retain skilled staff (WHO 2006). A valuable measure to be used in conjunction is ‘task shifting’: the process in which tasks are moved from more- to less-specialized health workers to expand the human resource pool and to allow more efficient use of the available staff (Samb *et al.* 2007; WHO 2007; Philips *et al.* 2008).

Current in-service HIV training programmes are not sufficient to meet the increasing demands and requirements of the rapidly expanding field of HIV care. We have to redesign the training curricula and introduce a system of continuous medical education and mentorship to ensure that staff is trained adequately and remains up to date with the current methods of treatment and care.

Most health facilities in resource-limited settings are incapable of diagnosing and treating certain opportunistic

infections (e.g. cytomegalovirus retinitis and multi-drug-resistant TB) and malignancies. TB remains highly under-diagnosed and untreated. Many patients with obvious clinical pulmonary or extra-pulmonary TB are denied TB treatment because no bacteriological proof of infection can be obtained. Without access to viral load testing, early diagnosis of ART failure – needed to avoid development of resistance – remains problematic. There is a lack of options in ART regimens to cope with side effects and treatment failure. For children, there is a lack of adequate ART formulations. Because of poverty, patients with HIV infection, particularly children, may die of malnutrition. Patient retention in ART programmes remains a problem due to lack of tracing systems and administrative and logistic problems. A significant proportion of patients lost to follow-up died since their last visit, thus leading to underestimates of ‘on-treatment’ mortality figures (Ferradini *et al.* 2006; Yu *et al.* 2007).

Most of the WHO guidelines on HIV treatment and care in resource-limited settings are based on expert opinion or on results of studies from industrialized countries. The Global Fund and PEPFAR spend an enormous amount of money to roll out ART in resource-limited settings (WHO 2006). To use this money in the most efficient way, more research is required to identify optimal treatment and care approaches.

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