

EDITOR'S CHOICE

E Cape dysfunction set to continue

One can only speculate on the eloquent silence of the Eastern Cape Health Department on *Izindaba's* coverage^[1] of the circumstances leading up to the premature departure of its Superintendent General, Dr Siva Pillay, in December last year.^[2] Could it be they'd rather not discuss the worrying regularity with which they stripped his stewardship of any particular aspect of health (e.g. the Air and Land Rescue Services function, after he fired the entire provincial leadership of its air rescue arm for spending R25 million illegal transporting private patients) or human resources (after he reversed R80 million per year's worth of irregular promotions) the moment he uncovered widespread corruption? He seems to have run into a brick wall whenever he tried to change things (e.g. rationalising healthcare facilities to match too-thinly-spread human resources, or taking on unions). That he feuded with his Health MEC, Sicelo Gqobana, is well documented. Yet simple personality differences fall laughably short of explaining the lack of support and the active in-house undermining he suffered. As 'Motsoaledi's man' (handpicked by the national Health Minister to try to resolve intractable Eastern Cape delivery problems), his provincial treatment exposes pitfalls in federal/national legislation that favour widespread endemic corruption and local 'solutions'.^[2]

Everything you need to know about thromboprophylaxis

The most recent update of the Southern African Society of Thrombosis and Haemostasis's 'Venous thromboembolism: Prophylactic

and therapeutic practice guideline' is published as part 2 to this issue of *SAMJ*.^[3] Venous thromboembolism is the most important preventable cause of hospital-related mortality,^[4] and in the absence of anticoagulation, the risk of deep-vein thrombosis in medically ill patients is comparable to that in moderate-risk surgical patients at 10 - 20%. Pulmonary embolism contributes to 10% of all hospital deaths.

The guideline is designed to be practical and concise, for use by general practitioners and specialists alike. It includes only registered indications at the time of submission but, importantly, provides guidance on the use of the new oral anticoagulants.

One of these new oral anticoagulants is dabigatran, now registered in South Africa (SA) for the prevention of cardioembolic stroke in patients with non-valvular atrial fibrillation (AF). An analysis in this issue^[5] suggests it is worthy of consideration as first-line treatment for stroke prevention in patients with AF. It is deemed cost-effective and is the only treatment that, when compared with warfarin, provides superior reduction in ischaemic stroke and haemorrhagic stroke.

Ten years of ART: how far we've come!

Next year marks the 10th anniversary of the rollout of antiretroviral therapy (ART) in SA. Since 2003, access to ART in SA has increased dramatically, leading to a decline of at least 25% in HIV-related adult mortality. SA now has the world's largest (1.8 million person) ART programme. There is no room for complacency, however. As Evans points out in her editorial,^[6] there remain significant obstacles both to access to ART for those who need it and to sustaining those already

on treatment. The disparity between rural and more highly resourced urban areas is just one of the challenges.

A solution, as Nyasulu and colleagues highlight in this issue,^[7] might be treatment in the hands of primary healthcare workers, which would increase ART uptake and reduce workload at referral facilities.

The SA HIV programme faces the problem of how to deal with the twin epidemics of HIV and tuberculosis (TB). Chimbindi and colleagues^[8] demonstrate that an integrated service, including HIV and TB testing and treatment, is convenient for patients, ensures timely initiation of treatment, and promotes optimal care of co-infected patients

NIMART (Nurse-Initiated Management of ART) offers high-quality, cost-effective care to more patients than a physician-centred model can. This 'task shifting' has already begun, but continued success will depend on adequate and sustainable training, support and salaries for staff in these new roles, the integration of such staff into healthcare teams, and compliance with regulatory bodies. With only 380 nurses per 100 000 people in SA (2011 figures), an inclusive approach of community-based organisations, home-based care or even caregivers themselves being able to access treatment may be essential for long-term sustainability of treatment programmes.

Such integrated care models for stable patients, which might

also include management of non-communicable diseases such as hypertension, diabetes and cancer, could be instrumental in the success of the proposed National Health Insurance scheme. But there will always be a need for referral facilities or specialty clinics for particular groups such as children, adolescents, pregnant women, or complicated or resistant medical cases.

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Introducing our authors



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* Chimbindi NZ, Bärnighausen T, Newell, M-L. An integrated approach to improving the availability and utilisation of tuberculosis healthcare in rural South Africa. *S Afr Med J* 2013;103(4):237-240. [<http://dx.doi.org/10.7196/SAMJ.6423>]

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