

A South African decade of antiretrovirals



It is hard not to call the last decade of antiretroviral (ARV) access anything other than a public health, human rights and political success.^[1,2] South African life expectancy has increased by a decade, almost entirely due to effective HIV treatment. The arrest

of mother-to-child transmission is one of the most celebrated public health programmes in the country, with transmission rates a fraction of what they were. HIV testing and condom usage rates are among the highest in the world. There are data to suggest that new HIV infection rates are going down and that the 2007 National Strategic Plan for HIV/AIDS goal of reducing new incidence by 50% is within reach. This may be due to a combination of condom access, antiretroviral therapy transmission arrest, or simply the natural trajectory of all infectious diseases, but seemed unattainable just a few years ago.^[3-5]

Questions of sustainability don't apply as much to South Africa as much as the rest of Africa. The HIV response is largely funded out of the national tax base, reflecting that political commitment is now more important than donor generosity, although there has been critical US Presidents' Emergency Fund for AIDS Relief (PEPFAR) and Global Fund technical and resource assistance in HIV programme execution and costing. There are legitimate concerns regarding the escalating cost of the programme. However, the combination of downstream costs averted by decreased hospitalisation and clinic visits, and aggressive negotiation of ARV drug costs with generic and originator manufacturers, has meant a sustained annual decrease in overall health costs over the last few years.^[6,7] Monitoring requirements have been eased and, owing to some task-shifting, the treatment cost per patient has decreased. Patients have access to third-line drug treatment, often not available even in developed countries.

Complaints that HIV draws more resources than it deserves are also easily countered. The virus, and its co-passenger tuberculosis (TB), used to account for almost half of all deaths in the country. While until 2004 resources allocated to HIV did not mirror the burden of disease, current funding levels now more accurately reflect what should have been allocated. The huge impact on health justifies the spend, with early indications that even TB incidence may be falling.

There is a lot to celebrate – there is sustained political and treasury support for a successful programme, thanks, in no small part, to a committed Minister of Health and cabinet. HIV debates have somewhat normalised, while a large number of human rights issues have been unveiled. High profile and precedent-setting court cases and debates have pushed the responsibilities of government, employers and manufacturers into an often-uncomfortable spotlight. HIV has mobilised large sectors of civil society and spawned a human rights focus on other areas, particularly provision of education.

But there is much to reflect on, not least the half-million South Africans that died due to the President Mbeki-era obstructionism and the failure of politicians and protection agencies to act. It is important to be honest about the history of ARV access.

There were clear heroes. Accolades have been deservedly heaped on the Treatment Access Campaign, Médecins Sans Frontières and Section 27 (then the AIDS Law Project), backed up by smaller and less vocal organisations such as the Southern African HIV Clinicians Society and the Rural Doctor Association. There were clear villains also. President Mbeki and his health minister, 'Manto' Tshabalala-Msimang, other ministers and provincial MECs, were responsible

for irrationality on the part of the National Department of Health. We are owed an explanation for the 'denialism' from members of Mbeki's cabinet who seemingly watched silently while so many died. Doctors will recall the grim role they played in the early 2000s, looking after patients, some of them AIDS activists, who died simply because access to life-saving medicines was prevented by a denialist government and high prices.

The Health Professions Council of South Africa and the South African Medical Association allowed the denialism to go unchallenged and were toothless when colleagues were fired for doing their jobs. Academic institutions also seemed cowed.

A small group of government health officials toughed it out and are owed an enormous and ongoing debt of gratitude. And the press, often the target of scorn, played their key role in telling the truth in the face of government hostility and disinterested readership.

Serial breakdowns of drug supply chains, largely due to weaknesses in provincial health delivery systems, show how the corrosive effect of the 'Manto era' continues to undermine the health system as a whole.^[8] As the complexity of National Health Insurance unfolds, HIV programmes, with all their established measurements, are well placed to provide a proxy indicator of health system performance.

It has been a roller-coaster ride. There are many valuable lessons for HIV and other disease programmes to learn from the last 10 years. The second decade will be every bit as eventful. We will require all our energies to build a health system that can provide the kind of quality of care that the HIV programme has dared us to imagine.



W D Francois Venter

Wits Reproductive Health and HIV Institute, and Department of Medicine, University of the Witwatersrand, Johannesburg, South Africa
fventer@wrhi.ac.za

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