Outcomes of a young ARV clinic within an established Family Practice

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Abstract

The letter reports on outcomes of a private HIV/AIDS clinic and questions its safety. The clinic (site 282) is a satellite to a PEPFAR (presidents emergency program for aids relief) funded and AURUM health supervised program. The clinic identifies itself from being different to the other programs in that it operates from within an established private Family Practice, has two specific doctors and limited counseling and no nurse support. In the rest of its content it has the same constraints as the government clinics. Using four recently published reports on HIV/AIDS programs it compares and comments on early outcome data. The conclusion is that provided good data are kept and improved with time, it would be safe to continue in this model.

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The purpose of this letter is to report on a private Family Practice based ARV clinic (site 282) funded by PEPFAR and supported by AURUM health, and compare outcomes with published literature. Patients are referred by GP's, clinics, pharmacies and the local ARV team. The model of care differs in some respects from the government clinics. Direct ongoing adherence counselling and nurse support is absent. Task shifting allows receptionists to double up as medication packers and dispensers, adherence counsellors and file managers. Emphasis is placed on patient centred care with a specific doctor. As a result it is important to report on the outcomes of this model, and compare them as far as possible with other data to ensure safety. Results reported for site 282 were abstracted from patient records. Table I below compares literature from four sites and site 282:

Discussion of table I:

Site 282 has the highest number of doctors in relation to enrollment figures! At this site the ARV work has been grafted onto an existing fully fledged practice. In contrast the Bela Bela group had a rapid project growth over 6 months. In addition to the 65 patients on ART they report 69 patients being eligible for ART but still being prepared for this. In site 282 this group was negligible, as patients moved rapidly to the treatment group once they were eligible.

The concept of a group called the decision to treat (DTT) has been taken from the Madwaleni study. The gender difference reveals that site 282 has more males on ART: 1: 1 male to female vs 2:1 in Madwaleni. This would be in keeping the perception that a 'private' clinic has less stigma than a busy government clinic, and that males in particular who are employed avail themselves to this care. The mean CD4 count in DTT group prior to starting ART, gives an indication of the immune status of the three reported groups at start of therapy. Of note in site 282 is that 3 patients were already on treatment with CD4 counts in the required therapeutic range above 400 cells/ul. This would increase the average CD4 count in this group.

Those remaining on treatment (% of total DTT) would co-incide with the period of the program. Using the percentage figures in brackets the range in the 5 reports is from 81-93%. The Lusikisiki group reports loss to follow-up and mortality combined at 19% for their clinics and 32% for the hospital. This implies that the clinic system offers better follow-up. Site 282 has a loss of 15% of the decision to treat group. Those who died on ART represent an important group. Each report notes these patients presented at a late stage with low CD4 counts (<50) and WHO stage 4 disease. Four groups report a similar loss of under 10%. Loss to follow up (unintentional loss) is an important consideration and has been reported to be due to lack of money (34%) and death (27%) in a big urban study involving a sample of 5849 patients.[5] The 4 reports have a low loss to follow up rate of under 4%.

The percentage of CD4 counts in DTT group of > 200 cells/ul at 6 months compares the immunological response to ART. For site 282 there were 3 out of 16 patients who had a CD4 count under 200 after 6 months treatment. The mean increase in CD4 Count in DTT group at 6 months is compared. Site 282 started with a higher mean CD4 count and one could expect a similar proportionate increase. The viral load at 6 months in DTT group is reported as both <400 and <50 viral copies per ml, the distinction being historical. The results are similar and show an acceptable response to treatment in all groups.

Table I. Results of five reports on ARV programs

Program	Madwaleni[1]	Lusikisiki[2]	Mosvold[3]	Bela Bela[4]	Site 282
Period of program	1 year	3 years	3 months	24 weeks	**18 months**
Setting	Government Rural clinic and hospital	Government Rural clinics Medicines Sans Frontiers	Government Rural hospital and clinic	Small rural town Church affiliated primary health care clinic. PEPFAR funded	**Peri-urban private Family Practice. PEPFAR funded**
Composition of team	2 doctors,3 nurses, 1 site-co-ordinator, 1 administrator,1 data capturer, 1 pharmacist, 1 social worker, 5 community health workers, 6 peer educators	5 doctors per 100 000, nurses and lay counselors (numbers not stated)	NS	1 doctor, part-time professional nurse and lay counsellors	**2 doctors and reception staff**
Total No of patients enrolled in program	513	NS	NS	335	**70**
Total No of patients in 'decision to treat'(DTT) with ARV's	191 (males 63, females 128)	595	100	65 (males 21, females 44)	**27 (males 13, females 14)**
Mean CD4 count in DTT prior to giving ARV's	105 (N=191)	NS	NS	79 (N=13)	**132 (N=27)**
Remaining on Rx (% of total DTT)	178 (93)	482 (81)	89 (89)	59	**23 (85)**
Died on ARV's of natural death (%)	9 (0,5)	100 (16,8)	7 (7)	4 (6,1)	**2 (7,4)**
Loss to follow-up(unintentional loss)	1	13	1	NS	**1**
The percentage of CD4 counts in the DTT group > 200 cells/ul	NS	87% at 12 months	NS	NS	**81% at 6 months**
Mean increase in CD4 count in DTT group at 6 months	131	NS	NS	NS	**196**
Viral load at 6 months in DTT group: < 400 and <50	88%	90% at 12 months	85%	NS	**94% at 6 months**

* NS means Not stated or reported in the reference.

Conclusions

Even though the numbers are still small Site 282 is not performing significantly differently from the other reports. Clearly ideal standards of care would expect no deaths on ART and no loss to follow-up and full CD4 count reconstitution with an absent viral load. As long as data is well monitored it should be a safe model and can be expanded and replicated in other Family Practice sites.

References:

1. Cook R, Wilkinson L. The Madwaleni HIV/ARV Programme. South African Journal of HIV Medicine 2006;23:18-24
2. Ford N, et al. Sustainability of long term treatment in a rural district: the Lusikisiki Model of decentralized HIV/AIDS care. South African Journal of HIV Medicine 2006;25:17-22
3. Fleet J. Mosvold Hospital ARV Programme. SAMJ 2007;97(6):390
4. Ndjeka NO, Manhaeve C. The experience of the Bela Bela HIV prevention group with the roll out of Antiretroviral Therapy at the Primary Health Care level. SA Fam Pract 2006;48(4) 56-57
5. Maskew M, et al. Lost to follow up- contributing factors and challenges in South African Patients on anti-retroviral therapy. SAMJ 2007;97(9):853-857

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