Editor's focus

Structural barriers to antiretroviral therapy adherence in South Africa

The important role of antiretroviral therapy (ART) for the management of human immunodeficiency virus (HIV)/acquired immunodeficiency syndrome (AIDS) is well established. However, there are factors that influence patients' adherence to ART. It is known that poor adherence to ART is highly predictive of viral load and drug resistance. Kagee et al[1] conducted a qualitative study to identify structural barriers that influence adherence among patients enrolled in the national ART programme at a Western Cape regional hospital. Semi-structured one-on-one interviews were conducted, recorded, transcribed and imported into a computer programme used for qualitative data analysis. Saturation of data was reached after a total of 10 purposefully selected subjects were interviewed. The emergent themes from the transcript were categorised into poverty-related, institution-related and social barriers. The chief structural barriers to clinic attendance were time away from work, transport expenses, long waiting times and negative experiences with clinic staff, while chief barriers to pill-taking were food insecurity, stigma and discrimination. Most of these barriers are not unique to HIV/AIDS, but are relevant in the management of most chronic illnesses. However, the findings of this study provide insight into possible implementation strategies to improve adherence to ART. A barrier such as food insecurity falls outside the competence of the health sector and should involve the Departments of Agriculture and Land Affairs. The authors conclude that a healthcare-enabling environment might play an important role in influencing healthcare-promoting behaviour among patients. The solutions are more complex than just fixing the healthcare-enabling environment, as other sectors within the public and private sectors have their important roles to play in enabling ART adherence, if the national HIV/AIDS programme is to be up-scaled.

Adverse effects profile of multidrug-resistant tuberculosis treatment in a South African outpatient clinic

In South Africa, just fewer than 2% of new patients with tuberculosis and 6.7% of retreatment patients have multidrug-resistant tuberculosis. Despite anecdotal reports of adverse events related to multidrug-resistant tuberculosis treatment, only a few studies describing the extent of the problem have been undertaken in South Africa. Jacobs and Ross[2] conducted a retrospective review on the adverse effects profile of a sample of 350 patients at the King George V Hospital Multidrug-Resistant Tuberculosis Clinic in Durban. They found that 80.6% of the patients had adverse events related to the medications, with hearing loss (28.7%), peripheral neuropathy (23.2%) and gastrointestinal symptoms (20.5%) topping the list. In addition, seven out of every 10 patients were co-infected with HIV and 85% were on ART. Obviously, adverse events were significantly more common in HIV-positive than in HIV-negative patients, particularly peripheral neuropathy, psychosis and confusion, hearing loss and thyroid disease. From the results, concomitant administration of anti-tuberculosis drugs and ART was not significantly associated with an overall incidence of adverse event,s but the likelihood ratios of individual adverse events occurred more frequently in HIV-positive patients who were also on treatment for multidrug-resistant tuberculosis. What stands out from this study is that clinicians should monitor these patients for the most common adverse events, especially hearing loss, which may become permanent.

Profile of maternal deaths in a district hospital in KwaZulu-Natal

The Millennium Development Goal (MDG) 5A aims for a reduction in maternal mortality ratio by 75% between 1990 and 2015. Globally, sub-Saharan Africa accounts for 57% of maternal deaths, and the South African maternal mortality ratio has shown a steady increase since 1990. In this cross-sectional study by Makinga et al,[3] the common characteristics and causes of maternal deaths, avoidable maternal deaths and quality of care were explored. A total of 61 maternal deaths were recorded during the study period, of which 63.9% were HIV-positive patients. The five leading causes of deaths were non-pregnancy-related sepsis (54.1%), miscarriage (14.8%), acute collapse (8.2%), pregnancy-related sepsis (6.6%) and anaesthetic complications (4.9%). In addition, about half (49.3%) received what was classified as "substandard" care. It is obvious that, for South Africa to achieve its MDG 5A target, the district health system must focus on quality improvement processes to address the causes of non-pregnancy-related sepsis and the substandard care offered at its public health institutions. This will entail on-going training of medical staff to recognise and appropriately manage non-pregnancy-related sepsis, and to identify the systemic issues resulting in substandard care. Staff burnout is one area that needs urgent attention as part of the turnaround strategy to address substandard care at our facilities.

Wishing you a pleasant and safe Christmas and festive period. See you in 2013!

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References

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