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WORLD HEALTH ORGANISATION GUIDELINES ON HIGHLY ACTIVE ANTI-RETROVIRAL THERAPY: IMPLICATION ON PALLIATIVE CARE PROVISION IN SUB-SAHARAN AFRICAN
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TO THE EDITOR IN CHIEF

WORLD HEALTH ORGANISATION GUIDELINES ON HIGHLY ACTIVE ANTI-RETROVIRAL THERAPY: IMPLICATION ON PALLIATIVE CARE PROVISION IN SUB-SAHARAN AFRICAN

W. K. TOO, S. MURRAY and K. E. KIMANI

INTRODUCTION

The World Health Organisation (WHO) recently published new guidelines for the use of anti-retroviral drugs (ARVs) for treating and preventing HIV infection. These consolidated guidelines aim to provide a public health approach for universal access to HIV treatment and prevention across the continuum of care (1). Although efforts to scale up ARV access are likely to dramatically improve survival, new challenges emerge for palliative care.

The WHO defines palliative care is an approach that improves quality of life of patients and families facing life-threatening illness. The aim of palliative care is not only to manage pain, but to prevent and relieve other physical, psychosocial and spiritual suffering commonly associated with advanced progressive illness (2)

According to the 2013 UNAIDS report , sub-Sahara Africa (SSA) bears the greatest burden of the epidemic as more than 69% of the 35.3 million people living with HIV reside in this region (3). Global efforts to scale up access to ARVs have resulted in a 33% decline in new infections and reduced deaths by up to 80%(3, 4). Access to ARV has markedly improved life expectancy and added at least 9 million life years to the region (4).

At the beginning of the epidemic, HIV was largely an acute and terminal illness where treatment was synonymous with palliative care (5). Few treatment options meant that palliative care was provided as end of life care after diagnosis. However, as scaling up universal access to ARVs is likely to improve survival, chronic HIV poses unique challenges for palliative care services (6).

HIV as a chronic illness: As people diagnosed with HIV live longer, they are at risk of developing chronic co morbid conditions commonly associated with aging. Hypertension, diabetes and non-AIDS cancers are now also common in people living with HIV. Multi-morbidity and drug interactions from multiple drug prescriptions are likely to produce a complex and unpredictable illness trajectory with severe distressing symptoms (7-9). Also, patients living with HIV may be faced with an additional emotional and psychological dilemma of returning to 'health' after being diagnosed with a known fatal illness (10).

These challenges of chronic HIV are not exclusive to patients. Caregivers, who take on the responsibility of providing support, may experience enormous burden as they adjust to the changing needs of those for whom they care. Similar to carers of patients living with chronic lung disease and heart failure, carers of patients with HIV have to cope with an unpredictable illness trajectory, complications from drug interactions and social isolation that occur with long term care (11, 12). In addition, health professionals may also be confronted with the complexities of managing drug interactions and chronic co morbid conditions alongside HIV care (10).

Palliative care for HIV: The WHO consolidated guidelines for ARVs recognise the important role of palliative care in controlling distressing symptoms and promoting treatment adherence. However, in regions such as SSA which have the greatest need, palliative care services remain scare (13).

In order to improve access to adequate care for chronic HIV, SSA is likely to benefit from integrating palliative care into existing health care systems. Stjernsward and colleagues argue that a public health approach may be the most effective way in which palliative care can reach populations with the greatest need. This approach includes (i) developing and implementing appropriate national policies, (ii) adequate drug availability for pain control (iii) education of health care workers and the public and (iv) implementation of palliative care services at all levels throughout society. The goal of this approach

is to ensure that communities take ownership of palliative care initiatives to support people living with advanced diseases including chronic HIV (13)

Lessons learnt from Uganda: In Uganda, Kitovu Mobile Palliative Care Service is an ideal model for integrating palliative care. Since its inception in 2000, the service, which is integrated with in a home based HIV care programme, supports local communities to provide care for those living with advanced illness (14).

In keeping with the public health approach to palliative care, Kitovu Mobile Palliative Care Service provides access to oral morphine, educates communities and train health workers in the principles of palliative care. This programme, which also integrates with local and national health facilities, has established referral pathways to ensure patients receive adequate care (14)

As access to ARVs improves and chronic HIV becomes a reality, a public health approach to palliative care may be a sustainable model for providing palliative care. Kitovu Mobile Palliative Service is an example of a model that has been successful in integrating palliative care(13, 14).

Other countries in SSA may benefit from a similar model that promotes collective responsibility and a grass root approach to palliative care.

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