CD4 counts and palliative care: time for a revisit

The realisation that no African country will achieve universal access to HIV care and support by the 2010 deadline set by the UN in 2005, is depressing if not unexpected news. Undoubtedly huge strides have been made, but the overwhelming feeling I get when visiting hospitals in many areas is that we're still not really thinking things through properly. To start with, we are starting ARV treatment too late. A CD4 count of between 200 and 250 (seems to be a common starting point) is too low. Many people are already too immunocompromised and the hospital wards end up overflowing with patients who, frankly, aren't going to get better. These people need to be in hospice care, not hospital care, but where in Africa have we developed the hospice movement effectively? Answer, not many countries. According to the African Palliative Care Association, only six countries have palliative care available in all districts of need (though 19 countries claimed to have such in a UNAIDS report!). Palliative care IS different to hospital care and it concerns me to see hard-pressed staff in hospitals trying to cope. They are under enough pressure without having to try to deal with terminally ill patients. If hospital staff could start their day thinking about making people better, it would make a huge difference to their morale and expectations.

Which brings us back to the CD4 count issue. Surely the point of intervention has got to be increased to maybe 400 or 450 or at least something much much closer to what prevails in Europe and North America. Yes, the number of people who will require ARVs will increase dramatically and that has an impact on all sorts of things (remember the original effort to get 3 million people on ARVs by 2005?). But good compliance will keep many HIV-positive patients well away from hospitals for many years and hopefully we can avoid the depressing sight of hospital wards being turned into unplanned hospices.

There is no doubt that enough lessons should have now been learned about implementing effective HIV testing and drug distribution programmes for the added roll-out to be efficiently sustained. Inevitably the funding squeeze will have an impact, but with prices of ARVs continuing to be reduced, it should be manageable. In time, the cost saving at the hospital ward level will also be hugely significant... and if these funds can be redirected into developing hospice care, then we would really have achieved some joined-up thinking.

Palliative care staff are excellent at providing chemo compliance, pain relief and all aspects of patient dignity. The potential of palliative care to change lives and reduce unnecessary suffering among patients and their carers is vast and must be realised.

All best

Bryan Pearson

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