



MESSAGE

From the Executive

At the outset, I ask that you forgive my odd poetic licence and mixed metaphors. This describes my journey as an HIV clinician in the decade that has seen us develop the biggest HIV treatment programme in the world.

I clearly remember the first day that our clinic started administering antiretrovirals (ARVs). It was the day that I wrote and passed the exam for the HIV Management Diploma, and I was unable to be at the clinic. It was only on 2 April 2004 that I went to the clinic. I looked in the drug cupboard and realised that we would finally be able to provide South Africans access to life-saving medication. For the next couple of months, as soon as I was finished at the research site where I worked, I went to the clinic at Helen Joseph Hospital to start patients on ARVs. In August of that year we celebrated with cake and tea after we had started our 1 000th patient on treatment.

Then it dawned on me that despite having initiated 1 000 patients in our clinic through all that work, time and effort, on that day the same number of people in South Africa had become infected with the virus. That was when I adopted the so-called 'starfish' approach.

The story goes that a man was walking along a deserted beach at sunset and saw a young boy on the beach, picking something up and throwing it into the water. When asked what he was doing, the boy replied: 'I am throwing these washed up starfish back into the ocean, or else they will die.'

'You can't possibly save them all, there are thousands on this beach, and this must be happening on hundreds of beaches along the coast. You can't possibly make a difference,' said the bystander.

The boy looked down, frowned for a moment; bent down to pick up another starfish, and smiled as he threw it back into the sea. He replied: 'I made a huge difference to that one!'

I loved telling my HIV stories or tales of starfishes: patients arriving looking like skeletons and getting better; my marathon-running HIV-infected patient; and babies so sick they were sent home to die, but having been started on treatment, are now at school. I even coined a term for this in our clinic: 'the Lazarus experience'. And my activist side was fuelled by the ongoing battles with the Mbeki-era denialist and our erstwhile Minister of Health, Manto Tshabalala-Msimang.

However, two things bothered me. The first was that South Africa became the laughing stock at international conferences, despite a growing ARV programme and good research emanating from the country. Quips about beetroot and garlic may have been taken in good humour, but I felt hard done by. We had a good grassroots programme staffed by dedicated healthcare workers who hated to see patients who could have been saved, die. The other was that tossing starfishes back into the sea was no longer enough for me. I wanted a more effective

approach to prevent the starfish from getting stranded on the beach and more effective ways of getting those who were stranded on the beach back into the sea. In retrospect, this was when I changed from being a clinician to more of a public health person.

Fortunately, this also coincided with the end of the 'Manto era', and within a short while, the appointment of Dr Aaron Motaaleli as the National Minister of Health. What the latter has done for the programme is immense. I have highlighted some of the aspects that I have seen in my work as really pushing forward access. Dr Motaaleli decreased the amount of red tape that clinics had to go through to become ARV sites, considerably decentralising the service. We now have over 3 500 clinics in South Africa providing ARVs. His ambitious aim to test 15 million for HIV was achieved. The mean CD4⁺ count on presentation is increasing and we are seeing fewer and fewer patients presenting *in extremis*. At the academic ward rounds that I attend every six weeks, we are now seeing older patients presenting with malignancies or long-term complications of antiretroviral therapy (ART). With the review of the guidelines in 2010, stavudine (d4T), a drug we all knew had severe side-effects, was removed from the first line and replaced with the gentler tenofovir (TDF). Finally, the fixed-dose combination means that most patient have to swallow just one pill once a day.

So ten years down the line, what is my role in the ARV programme? As an activist, I am perplexed. The National Department of Health is making all the right noises, but we still need to be vigilant in ensuring that they keep their promises. This includes keeping an eye on stock-outs and making sure that no one is turned away from clinics on the basis of their nationality. I need to keep up with the latest research and do what I can to ensure that when a significant development takes place, it is included in policy. Most of all, I must just do what I can to support the programme with clinical advice, training and advocacy.

While much has been made in the media of getting to zero and the end of AIDS – we are getting closer than ever before – if we let up now, we will see an increase in HIV-

related morbidity and mortality. We need to buckle down and do the work of testing and treating all who come to our doors, and of ensuring that they adhere to lifelong ART.



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