

View Point

Accessibility of Antiretroviral Treatment (ART) services in Nepal

Kiran Thapa

*Institute of Medicine, Maharajgunj Medical Campus
Kathmandu, Nepal.*

kirangagan555@gmail.com

Abstract

Antiretroviral treatment (ART) services have been proved to be very effective in treatment and prevention of HIV/AIDS worldwide. This paper is aimed at whether ART services in Nepal are accessible to people living with HIV (PLHIV) and also tries to explore some barriers to accessibility of ART services. It has been more than a decade since ART services have been started in Nepal. But still, it has not been able to reach all the people who are eligible for treatment. Despite numerous efforts from government and non-government sectors, socio-cultural and managerial issues limit PLHIV's access to ART services.

Keywords: accessibility; ART; PLHIV; Nepal.

Access, in its most narrow sense, refers to physical accessibility. A far broader definition identifies four overlapping components of accessibility: non-discrimination, physical accessibility, economic accessibility i.e. affordability and information accessibility. (1) It is sensible to consider access in terms of whether or not those who need care obtain it (Aday and Anderson 1974). 'The proof of access is use of service, not simply the presence of a facility. Access can, accordingly, be measured by the level of use in relation to "need"...' . (2)

ART is a life saving treatment for HIV infected people. Antiretroviral drugs transform AIDS into a chronic illness for adults and give infected children a future. (3) The advent of ART has dramatically reduced AIDS-related mortality by slowing down HIV progression. AIDS has now become a more manageable chronic illness, rather than a fatal illness. (4, 5)

The United Nations addresses HIV/AIDS in its sixth millennium development goals by stating to combat and reverse the spread of HIV/AIDS by 2015 as well as to achieve universal access by 2010. (6) Moreover,

the National HIV/AIDS Strategy 2011-2016, also embraces the principal of universal access, human right based approach and multi-sectoral approach to guide the national response to HIV which is premised upon the National AIDS Policy 2011.

Nepal has been providing free-of-cost ART service since 2004 and by the end of December 2013, the total cumulative number of people living with HIV (PLHIV) ever been on ART increased to 11,704 while those currently on ART increased to 8,866. Even with the consistent increments of PLHIV in ART enrollment for the last half a decade or so, only around 21.8% of eligible adult and children living with HIV are receiving ART which highlights that an alarming gap between the estimated 48,600 HIV infections and a total of 22,994 reported cases that needs to be bridged. (7-10)

Since 1995, ART has saved 14 million life years in low- and middle- income countries, including 9 million in Sub-Saharan Africa. However, there is gap of about 46% between people who can access treatment and people in need. This gap is set to increase as the de-

mand for services continues to rise and increasingly transcends availability. (11) Africa is leading the world to expand access to ART services but considerable work remains to reach all people eligible for HIV treatment, with antiretroviral therapy reaching only about one in three eligible according to the 2013 guidelines. (12)

HIV prevention services and life saving medications should be made accessible to people in need in order to achieve the UNAID's vision of zero new HIV infections, zero discrimination and zero AIDS-related deaths. Despite numerous efforts by Nepal Government, the existing gap between the top level and grass root level has prevented to expand HIV prevention and treatment services to reach the at-risk populations. (3) Despite improvements in the legal and policy landscape, gender and social inequalities still persist and are increasing the vulnerability of certain groups to HIV and obstructing their access to services. (7) High level discrimination against HIV infected persons, identification and willingness to undergo diagnostic procedures puts a serious barrier for many people. (13) HLM Review conducted by NCASC in 2013 reported incidences of discrimination by health care providers are regularly reported even where equitable services are available.

There has been a robust expansion of ART services up to 44 sites within a decade, most of which are constrained in urban areas but laboratory facilities that complement ART services have not been scaled up in parallel with the expansion of ART sites. (7, 13) Important ART monitoring tests (CD4 testing, liver function tests (LFT) and renal function tests (Creatinine) are carried out only at teaching hospitals and zonal hospitals, putting them out of the reach of many patients from remote districts due to cost, time and distance. (7)

The uneven access to treatment within the country due to distance made PLHIV difficult to manage out-of-pocket expenses, such as additional costs incurred through travel, diagnostic tests, nutritional and other user charges. (3, 13) Similar findings were reported in Botswana where 12% of ARV clients did not receive Antiretroviral (ARVs) treatment because they could not afford to pay for transport. (14)

Nepalese migrant workers communities have low awareness about HIV/AIDS. PLHIV often have inadequate knowledge about counseling, and counseling

and testing services are difficult to access for PLHIV. (13) On the other side, due to fear, negative perception and poor health seeking behavior, majority of the Nepalese PLHIV do not know their status and so many may continue to engage in unsafe sexual practices. (3) Among total men and women of age group 15-49 who received an HIV test in past 12 months, only 7.5% men and 2.9% women knew their results. (15) Similarly, 58.5% MSWs, 54.6% FSWs, 42% MSM and 21.4% IDUs knew their status who have received an HIV test in past 12 years. (16-18) Less than 33% of MSM tested in the past 12 months know their HIV status in South and South East Asia. The gender gap in services for drug users makes women who inject drugs more vulnerable to HIV due to limited access to HIV services. It is estimated that only half of all PLHIV knew their HIV status at the end of 2011. (11)

The use of more effective ARV regimens and the expansion of prevention of mother to child transmission (PMTCT) programmes helped prevent more than 800,000 children from becoming newly infected between 2005 and the end of 2012. (19) PMTCT services are now offered at 65 sites in 33 districts across the country (HLM Review, 2013, NCASC 2013). Only 20.5% i.e. 139 HIV positive pregnant women received ARV to reduce the risk of mother to child transmission. (20) PMTCT programme will be one of the points of entry for ARV but various issues and challenges such as limited testing, counseling, poor referral mechanisms and stigma are acting as barriers to reach the HIV treatment services in Nepal. (3)

TB-HIV co-infections have emerged as a health problem in recent years. Antiretroviral therapy reduces the risk of tuberculosis infection among people living with HIV by 65%. (21) The sentinel site survey conducted in 2011/2012 showed 2.4% TB patients are living with HIV and 11.5% people living with HIV are co-infected with TB (NTC, 2013). TB related AIDS deaths fell by 25% and 28% worldwide and in Sub Saharan Africa respectively in between 2004 and 2011. This is due to increasing numbers of people with TB/HIV co-infection accessing ART- a 45% increase between 2009 and 2011. (11)

Adolescents (10-19 years) are the only age group in which there is rise in AIDS-related deaths from 2001 to 2012. (12) However, there are insufficient data currently to accurately determine the numbers of adolescents who need and receive ART. (19)

Reliable estimates of ART coverage are not available for Men who have sex with men (MSMs), Intravenous drug users (IDUs), sex workers or transgender individuals. However, there are strong indications that key populations face substantial barriers to access essential health services and have extremely low access to antiretroviral therapy. (12) There are significant gaps in data on key populations, including the lack of disaggregated data on the various MSM sub-populations, males and females who inject drugs and FSW who use drugs. (7) In countries with concentrated epidemics like Nepal, it is challenging to estimate service needs and coverage among women at highest risk of HIV. (11)

As of June 2013, 1,343 PLHIV were referred for ART management through community and home based care (CBHC) services in 66 districts. Similarly, 1,011 PLHIV received ART admitted to community care centres (CCC) available in 36 districts. (10) Strong bidirectional referral linkages between CCC, CHBC program and ART sites to facilitate the quality of ART services, especially in ensuring adherence and follow up of PLHIV on ART and HIV-positive mothers and infected and exposed babies, have played important roles in enhancing ART coverage as well as in supporting retention and adherence to ART. (7)

In order to ensure equitable access to prevention and treatment services for frequently marginalized populations like MSM, sex workers and IDUs in the concentrated epidemic settings, steps should be taken to coordinate HIV diagnosis efforts with community organizations (22)

Conclusion

Despite various efforts by the government and NGOs, there is yet to be done to make ART services accessible to all PLHIV. Inadequate access to ART services hinders right to health of PLHIV. Overcoming barriers to accessibility of ART services need well-coordinated efforts and greater involvement of people with AIDS (GIPA). Community models could play significant role in scaling up ART services. High risk groups should be focused while scaling up intervention programmes. Expansion and integration of HIV testing and counseling (HTC) and ART services by strengthening the overall health system could aid to achieve universal access to ART.

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