Leveraging HIV/AIDS and NCDs for strengthened chronic care systems

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EVEN though HIV/AIDS remains the main cause of adult death in sub-Saharan countries, concentrated epidemic is being observed in Asian countries among the most at risk people like injected drug users. The burden of non-communicable chronic diseases (NCD) in such countries is also high and growing rapidly. This phenomenon is not something new, however, regrettably, most developing countries face the new challenges of NCD at the same time as the challenges of communicable diseases and threats to maternal and child health.

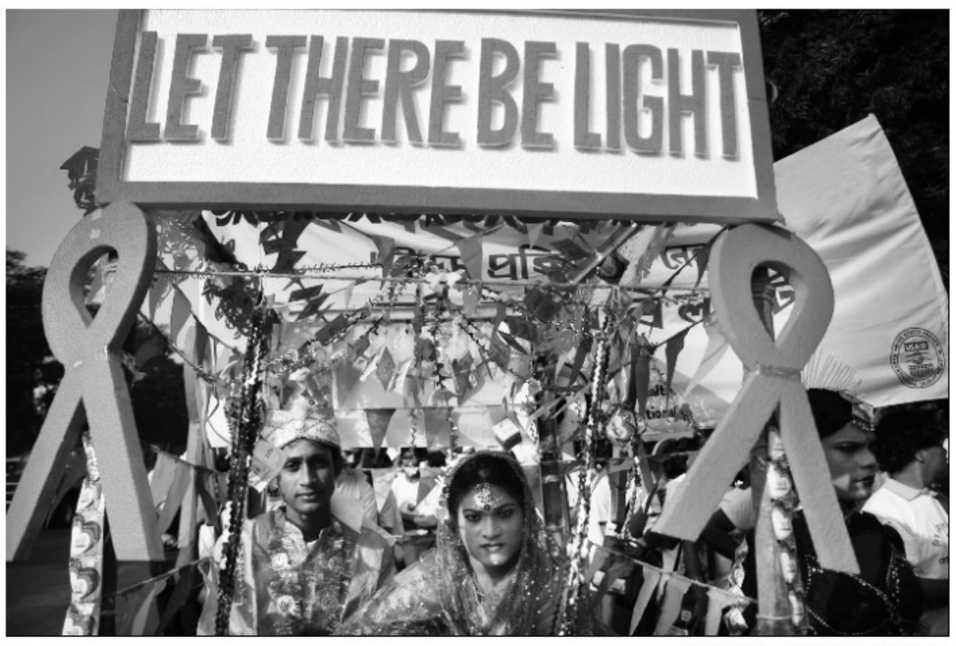
This burden of two kinds of diseases -- both needing constant care -- is putting extra pressure on the health care system of these countries, which are already having hard time in providing the integrated and coordinated services required to address chronic care. Therefore, very few persons living with NCDs and HIV in resource-limited settings have access to appropriate health services, leading to deferred diagnosis and unnecessary death and disability.

Global guidelines and conceptual frameworks for NCD programmes are available for integrated and unified activities. However, very few developing countries have national NCD programmes providing nationwide activities for NCD prevention, care, and treatment services. Because of this, the health systems in resource-limited settings are hardly able to deliver continuous services of any kind and typically provide only short-term care for acute symptoms or problems. Even though HIV and NCD are thought of as quite different challenges, both these diseases need constant care systems.

Fortunately, due to the availability of global funds in the health systems throughout the developing countries, tools and approaches needed to support continuous care in the local context have been developed. These models and approaches can be used for tackling NCDs as well. However, it goes without saying that the lessons of HIV care will not be always suitable for all NCD programmes or in all contexts. However, rather than "reinventing the wheel," resource poor countries may be able jump-start NCD programmes by adapting locally owned and locally validated approaches initially developed to support HIV prevention, care, and treatment services.

One of the success stories of HIV programmes is leading to a remarkable expansion of HIV treatment, reaching 6.6 million people compared with half a million 10 years ago. This is a lesson that the NCD programmes can learn. At a global, or "upstream," level, NCD experts have developed multi-sectoral partnerships inclusive of civil society and achieved a high-visibility platform in the United Nations meeting. But the key question is the same for both, should there be a global fund for NCD or should advocates press instead for NCD services to be included in primary health care programmes and for efforts to strengthen broader health systems?

In both the cases, key lessons from HIV programmes include the influence of unambiguous conscription targets to leverage resources and promote accountability; the value of engaging civil society and recipients of services to improve programme quality and adequacy; the need for novel financing schemes; the importance of leveraging the private sector; the multiple challenges of primary prevention; the importance of access to diagnosis, care, and treatment; and the power of a rights-based framework.



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On the other hand the "downstream" resources include key tools, and on the ground strategies and systems developed to support the implementation of HIV programmes that could be tailored to support programmes and services for NCD. However, we have to keep in our mind that the magnitude of NCDs is much higher than HIV in many countries, therefore NCDs need more decentralised activities embedded at community and primary care levels.

One way of leveraging these two challenges of the decade is to compile a "package of care" for each level of the health system, including features like the use of standardised step-by-step diagnosis, care, and treatment protocols; the promotion of simplified point-of-service diagnostic testing; the use of simple and powerful indicators for monitoring and evaluation; and the development of enrollment targets at facility, locality and national levels. Paradigms of systems used by HIV programmes that could be stretched or "cloned" for use in NCD initiatives include decentralised community-based diagnostic testing; appointment and defaulter tracking systems; laboratory networks and referral systems; task-shifting and task-sharing approaches; clinical mentoring and supportive supervision; and the systematic use of peer educators. However, not all of these will be applicable to every NCD programme or in every context, but many valuable, practical, contextually appropriate and easily adapted resources could be used to jump-start service delivery.

The most important aspect of this leveraging issue is that there are important differences between HIV and NCD that may limit the relevance of some of these resources. Both diabetes and HIV are diagnosed via laboratory testing and treated at some stages with daily medications; both require regular clinical and laboratory monitoring and support for adherence and behaviour change. In contrast, some cardiovascular diseases and cancers may be considerably harder to diagnose and treat at the health centre and community levels. Issues of stigma may shape programmes for HIV and mental health more than those designed for other NCDs. If significantly more resources become available, it might not be difficult to implement large-scale NCD programmes of any kind.

It does not matter if the NCD initiatives are organised as "vertical" disease-specific or "horizontal" health systems-strengthening programmes, or as an amalgam. Addressing the burden of NCD in developing countries like Bangladesh requires an intensive, well-resourced multi-sectoral effort. And overlooking the potential of local HIV programmes to catalyse NCD service delivery would be a mistake. Leveraging the experience of HIV prevention, care, and treatment initiatives may take different forms. In some contexts, amalgamation of services for all chronic diseases -- HIV and NCD -- would be the best approach. In others, programmes might not get integrated at the point of service but may draw upon similar systems, from monitoring and evaluation to procurement. The take home message is that strengthening health systems to deliver continuous care is likely to enhance the performance of both HIV and NCD programmes, and should be top priority.

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Nutrition for HIV infection and AIDS

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"DO we eat to live" or "live to eat"? The first statement is true for all of us and the second is also true sometimes when our enjoyment of food is more important to us than the sustenance. This is the case for normal humans being like us, but it is different for Persons Living With HIV/AIDS (PLWHA). Nutritional care is just as important as medical care for people with HIV infections. Nutritional care and medical care are interdependent, and if we ignore either of these the other will surely suffer. The infection itself disrupts the body's capacity to make use of nutrition. The HIV virus most often causes three nutritional problems:

- Diminished appetite;
- Less efficient nutrient absorption; and
- Changes in the metabolic way of utilising food.

All of these lead to malnutrition, which is a major problem for PLWHA. The most severe symptom of malnutrition in people with HIV infection is weight loss, and it is essentially related to macronutrient (carbohydrate, protein and, fat) deficiencies, not micronutrient (vitamins and minerals) deficiencies. Macronutrients give us calories while micronutrients do not. So, PLWHA should manage their diet so that it meets their macronutrient needs and spend less time on how to meet their micronutrient needs. This should be the most important principle for PLWHA.

General nutritional information is okay for most normal people but not appropriate for people with HIV infection. True to say, very few foods are bad for PLWHA. Sugar is alright and salt can be taken. Red meat, saturated fats, and dairy products are fine, and the infected person should be encouraged to consume these things in their daily diet. But one vital thing should be kept in mind, they should avoid foods that could be a contamination risk, especially raw fish, raw meat, raw eggs, unprocessed honey and foods that are more than two days old. Low-fat and low-cholesterol diet is not suitable for PLWHA.

Based on positive nutrition pyramid experts suggest eating the foods listed below every day:

- Consume twice the normal amount of conventional high class protein (meat, poultry, and fish) daily. This could be 100-120 grams for men, 80-100 grams for women. About 450 grams of meat, poultry, or fish contain about 110 grams of protein;
- At least 2 servings of fruit and 3 servings of vegetables;
- At least 2 servings of milk (2 glasses); and
- Enough calories from carbohydrate and fat to keep the weight of the PLWHA stable.

Sometimes the medical issues take primacy over the nutrition-related aspects of health. This is wrong. Food and medicine should go hand in hand for the treatment of the HIV infected people.

By following the positive nutrition pyramid, PLWHA receive the Recommended Dietary Allowances (RDA) for micronutrients (vitamins and minerals). It is recommended that HIV infected persons should take multivitamin supplements, which provide the vitamins and minerals missing in the diet. Their diet should also contain a safe and recommended amount of trace elements like manganese, copper, chromium, and selenium. The following additional supplements are also recommended for the PLWHA: Vitamin C (500-1000mg), Vitamin E (10-40 IU) and beta carotene (6 mg). Overdosing of other nutrients is not necessary and may be harmful.

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Two mayors for Dhaka city

HUSSAIN IMAM

THE government has divided Dhaka City Corporation (DCC) into two, with each having a mayor. The bill to that effect was passed in the Parliament on Tuesday.

The BNP chairperson and leader of the opposition Begum Khaleda Zia and her party members have strongly protested against the decision. Even some components of the grand alliance government of Sheikh Hasina like Worker's Party (Menon) and JSD (Innu) are against it. So are most of the urban planners and eminent citizens of the country.

According to Mayor Sadek Hossain Khoka, the decision to divide DCC is in no way going to serve the purpose of giving better service to the citizens of Dhaka. It will, on the contrary, make matters more complicated and increase the miseries of the citizens.

The problem is, it is difficult for the people of this country to believe in what the opposition camp says, because it has become a habitual practice for the opposition to oppose every move -- good or bad -- the government takes. In this case also, who can say whether BNP is opposing the move seriously believing that the decision to divide the City Corporation is going to have negative impact or is it because of their usual practice of opposing every move that the present government takes?

Prime Minister Sheikh Hasina has other views. She thinks, at least that is what she says, that by having two corporations and therefore two mayors for Dhaka, people will have better service. According to her, Dhaka is now too big for one mayor to manage things.

Her critics from the opposition camp think she has done it to axe Sadek Hossain Khoka from the post of mayor.

Whatever may be the reasons, the argument that Dhaka is too big for one mayor to manage is not very convincing. If cities like New York, London, Tokyo or Kolkata can be managed quite efficiently by one mayor, why can't Dhaka be? Is Dhaka bigger than these cities? It is certainly not.

How much the people will be benefited by this division remains to be seen. It is, however, certain that with the division of the Corporation the overhead cost of city administration is going to increase substantially, and this money has to come from the pockets of the city dwellers. We believe that it is not the size of manpower that matters most for good governance of an organisation. It is the system and the sincerity, honesty and dedication of the people who work there which are more important than anything else.

Sadly, that is where the DCC is miserably lacking. Mayor Sadek Hossain Khoka is right when he says that the division of DCC will not serve the purpose of giving better service to the people. It will only complicate the situation. Mr. Khoka has been in office as mayor of the city for nearly 10 years. Who knows better than him that it is because of lack of sincerity, honesty and dedication to serve the people on the part of himself and his office that he has not been able to provide even the minimum service to the citizens of Dhaka?

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Who knows it better than him that it is because of rampant corruption, gross negligence in duty, utter indifference towards responsibility on the part of his office, not because of the size of population or area of the city, that the inhabitants of Dhaka city are deprived of even the minimum facilities of a civic life?

Look at what has happened to Dhaka. It is in dire straits, to say the least. Roads dilapidated. Pavements are either missing or illegally occupied by hawkers, traders and house builders. Public transport facilities are too inadequate to meet the demands of an ever burgeoning population. Traffic jam has been a constant hazard. The fares of rickshaw and CNG, the only mode of transport for the middle class families, have reached an all-time high. Nobody knows for sure who is responsible for what. About cleanliness of the city, the less we say the better it is. Then there is the crisis of utility services like water, gas, electricity. There is the problem of children's education.

All these problems are not necessarily the responsibility of the DCC to solve single- handedly. But some of them are certainly their's. For others, there are different agencies of the government to look after and these agencies are almost independent of one another. DCC has very little authority to make them work unless they themselves are willing to work. It is not clear how the division of DCC is going to solve these problems.

One thing we know for sure is that it is the duty of DCC to keep the city clean and free from mosquitoes. Have they done their duty properly? If they had, why is it that the whole city now looks like a huge dumping ground of sand, dust and waste, and has become a safe breeding ground for mosquitoes? Does it need two mayors to clean the city? These are the questions the prime minister should have addressed first before going for a division of the corporation and increasing the overall cost of city administration.

It is so strange that when the finance minister is apprehensive about financial problems, if not crisis, in the days ahead in the wake of persistent economic meltdown worldwide and is asking for tightening the government exchequer's belt, the prime minister has decided to divide the DCC and increase the cost of its administration without any tangible gain in sight.

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