EDITORIAL

Decentralisation and task-shifting in HIV care: time to address emerging challenges

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The WHO public health approach, which had service decentralisation and task-shifting at its core, played a critical role in improving access to life-saving treatment in resource-limited settings.¹ During the early years of antiretroviral treatment (ART) scale-up, the recommendations for decentralisation and task-shifting was a necessity due to the meagre infrastructure and human resources available in settings with a high HIV burden. Although initial recommendations were not supported by evidence, subsequent studies provided reassuring evidence that HIV treatment outcomes in nurse-led settings were comparable with those of physician-led ones.² With the expansion of the goal of ART to include long-term viral suppression and prevention, the need to update the public health approach to encompass a range of services from prevention to care was highlighted.³ With further changes in the dynamics of the HIV epidemic, including high rates of non-communicable diseases among the ageing population of people living with HIV (PLHIV), the need to re-examine how the emerging needs of these patients are being addressed is evident.

In this issue of *Public Health Action*, McHugh et al. compare services offered to adult clients attending a physician-led service for HIV care in a hospital-based outpatient HIV clinic and those offered in a nurse-led primary care clinic in Harare, Zimbabwe.⁴ Their findings highlight important similarities and differences in the range of services provided at the two levels of health care settings. The level of viral suppression was comparable in both settings but the hospital-based clinic performed better in a range of parameters. This included higher frequency of viral load measurement, shorter patient waiting time, better isoniazid preventive treatment uptake rates and higher rates of screening for chronic comorbidities such as renal diseases and cervical cancer.

The study has important limitations, as noted by the authors. The report was based on self-reported cross-sectional data in just two health facilities. The higher but statistically non-significant rate of viral suppression in the primary health setting, for example, may be due to selection bias, as those with unsuppressed viral load are more likely to be referred to hospitals. Also, higher screening rates for chronic diseases could be associated with higher rates of more complicated cases in hospitals.

Despite these limitations, the study highlighted important areas for further action. Decentralisation and task-shifting should be accompanied by adequate and continuous capacity building in primary care settings, including training of health workers on emerging comorbidities. Also, primary care settings should be equipped with better facilities such as adequate specimen transport and laboratory testing capacity. Further evaluations using more rigorous study designs for evaluating the expanded public health approach for HIV care are needed. This would make it possible to see complex issues beyond viral load suppression. This is particularly important under the current circumstances, where HIV services are being further compromised by greater attention paid to the unprecedented COVID-19 pandemic.

References

- 1 Gilks CF, et al. The WHO public-health approach to antiretroviral treatment against HIV in resource-limited settings. *Lancet* 2006; 368(9534): 505–510.
- 2 Uebel KE, et al. Task shifting and integration of HIV care into primary care in South Africa: the development and content of the streamlining tasks and roles to expand treatment and care for HIV (STRETCH) intervention. *Implement Sci* 2011; 6: 86.
- 3 Ford N, et al. The WHO public health approach to HIV treatment and care: looking back and looking ahead. *Lancet Infect Dis* 2018; 18(3): e76–e86.
- 4 McHugh G, et al. A comparison of HIV outpatient care in primary and secondary healthcare level settings in Zimbabwe. *Public Health Action* 2020; 10(3): 92–96.

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