Letter to the editor of *The Lancet*

**Palliative Care in Sub-Saharan Africa.**

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Sir

We agree with Harding and Merriman et al(1,2), that improving palliative care services for persons living with HIV/AIDS in sub-Saharan Africa remains extremely important despite the increased access to antiretroviral treatment (ART).

On the other hand it should be emphasised that by far the most effective means of improving symptoms and the well being of patients with AIDS is by successfully treating opportunistic infections (OIs) and initiating ART. With simple affordable drugs and the free provision of anti-tuberculous and anti fungal therapy the vast majority of OIs may be cured. Numerous studies have demonstrated the effectiveness of ART in Africa (3,4,5).

We therefore agree with Merriman’s view that palliative care in the era of ART should be clearly defined.

ART providers need to concentrate on the successful management of OIs and effective ART. Effective ART care must include excellent management of
adherence, toxicity, immune reconstitution events and first line treatment failure as suggested by Harding – but this should be a prerequisite of ART providers. Those providing palliative care services should not duplicate this work. Doing so would be a waste of limited resources and dilute the important role palliative care still has to play as emphasised by the authors above. Unfortunately a number of patients will fail first and second line ART. 3rd line treatment is not available and so the outcome for these patients is poor. Treatment for opportunistic neoplasm’s remains unavailable for the vast majority of patients. Many patients on the generic combination Triomune will suffer highly symptomatic neuropathy but will be unable to switch treatment due to financial constraints or drug availability. Finally some patients will present to ART providers too late for successful treatment and will need, as a matter of urgency, home based symptom control and holistic care during their last days or weeks.

Agencies funding palliative care services for HIV patients should target organisations with the skills and passion to deliver effective palliative care services to large numbers of patients. Donors should also seriously consider providing non ART funds for patients with conditions that are amenable to treatment were it available. For example the symptom control and quality of life of patients with Kaposi’s sarcoma and CMV retinitis may be best achieved, not by palliative care, but with the appropriate specific therapy – which may be very cost effective if ART is also available.

Ideally all ART programmes should have access to palliative care services for those patients who need it. This may be through the training of interested
personnel or through networking with local organisations specialising in home based palliative care such as Hospice Uganda.

Palliative care centres must be aware of what is locally available in HIV care, so as to know when to refer on to ART providers if necessary. Knowledge of drug interactions between ART and the agents used in palliative care is also important. Finally when to stop ART in resource limited settings is an important question for failing patients and one that should answered using the appropriate evidence.

Colebunders R¹,²,³, John.L², A.², Lynen.L¹, Kambugu.A²

¹ Infectious Disease Institute, Faculty of Medicine, Makerere University, Kampala, Uganda
² Institute of Tropical Medicine, Antwerp, Belgium
³ University of Antwerp, Antwerp, Belgium

References:
