Although he was not aware of any local black-market ARV drug smuggling, he agreed that there was potential for money to be made by unscrupulous private practitioners. Wood said the cheapest generics on the market (not licensed but on Section 21) came from India and cost the patient about R20 per month.

Zokufa said that unless compliance and monitoring were handled properly, all the efforts the government was making to get drugs on tender at very reduced prices would be ‘reduced to naught’.

‘We’d then have to look at second- and third-generation ARVs at much higher prices, and we’d be back to square one, chasing our tails.’

The pharmaceutical industry needed a market for their second- and third-generation ARVs.

‘We must do the first-stage roll-out very well – as it is, we’ve moved faster than we’d have liked to.’

While the quotation system was being used as an interim measure to purchase ARV drugs, tenders would ‘definitely’ be finalised by the beginning of September.

Drug planning centred on supplying 450 000 people with ARVs.

‘Obviously not everyone will show up on day one – we’ll probably hit that figure in 6 - 8 months’ time,’ Zokufa said.

Chris Bateman

Public health care workers have a year longer than their recently shaken private counterparts to comply with the tightened-up drug dispensing regulations and will be equally bound by them from 1 July next year.

In spite of the extra time, provincial human resource and pharmacy departments are scrambling to make sense of the plethora of interlocking laws aimed at improving service delivery and creating greater accessibility to health care.

Contrary to the fiercely contested but ultimately accepted inception of the dispensing section of the Medicines Act by the private sector, some in the public sector are viewing the changes as an opportunity to review best practice.

Says Margaret van Zeil, head of pharmacy practice and legislation in the Western Cape provincial administration, ‘for example, if we think we may need 20 – 30 nurses licensed to dispense at a hospital, that assumes they need to dispense after hours for patients discharged on a Friday night or Saturday afternoon. So instead we question why we’re dispensing medicines on a Friday night or Saturday morning and look at doing things differently.’

Her boss, Mrs Vonita Thompson, Director of Professional Support Services for the Western Cape, added, ‘basically we’re almost re-engineering the services, talking with every regional director and detailing and modelling every region’.

Van Zeil said the support being received from top provincial management was ‘heartening’. 
schedule medicines in terms of their own current Nursing Act, provided they are authorised by a clinician or their medical superintendent who must take full responsibility for them.

By 1 July next year, they will need to have completed their 300 notional hours of pharmacy training and write the Pharmaceutical Council exam if they are to dispense drugs – and then function strictly according to good pharmaceutical practice.

This will involve, among other requirements, storage temperature controls, record keeping, distribution of medicines, advice, proper facilities – all of which were, according to Sue Putter, a private pharmaceutical consultant and former senior manager of professional affairs at the Pharmaceutical Council, ‘applied too loosely in the past’.

The new ‘upgraded’ Nursing Act will also prescribe the scope of practice of different categories of nurses and more strictly define which nurses may do what, what training they need and which drugs they can prescribe. ‘It’s motivated by quality of care – the current dispensation is much too loose,’ says Putter.

‘Also our people do locums and outreach programmes, so this would be vital,’ she said.

What was also unclear to provincial managers was whether provincial health departments would have to pay the R1 500 fee per person to apply for the dispensing licence and then the additional R800 per person for the ensuing 3 years.

Thompson said estimates were that it would cost her province and its local authorities R52.39 million to comply with the Medicines and Pharmacy Acts.

The bulk of this (R50 million) was to upgrade existing facilities (e.g. air conditioning, refrigeration, private counselling areas), while training costs for clinicians, nurses and pharmacy assistants made up the remainder (which the province would pay).

There was no funding within the current provincial budget to offset the projected additional expenditure and her staff had done extensive costing ‘to give us a tool to approach the national department for additional funds’. They were currently awaiting a response from national DOH on how licensing would be paid for.

Actual training needed to begin immediately if they were to avoid being compromised by next year’s legal deadline.

Van Zeil’s workshops revealed confusion among nurses and clinicians over the difference between the administration and the dispensing of medicine (the former an exact, direct dose in front of the health care practitioner and the latter more than one dose given in a labelled container to be taken away for later consumption).

‘We’ve got people thinking they need a dispensing licence when all they are doing is administering medicine,’ said Van Zeil.
Within 6 years, HIV-positive South African mothers may be able to confidently and safely breastfeed their HIV-negative infants to natural weaning without transmitting the virus, thus significantly reducing the overall risks of infant mortality.

That is the goal of an ambitious and groundbreaking NIH-funded research project initiated by Professor Jerry Coovadia, Victor Diatz Professor of HIV/AIDS Research at the University of KwaZulu-Natal's Nelson Mandela Medical School.

Based on the likelihood of developing a single prophylactic injection to the infant every 2 - 3 weeks, the new methodology promises to boost the already impressive drop in HIV-positive infant prevalence brought about by the current expanding roll-out of antiretroviral PMTCT drugs.

Tackling HIV breastfeeding transmission head-on instead of becoming mired in the often emotive and contentious 'Third-World-formula-feeding' debate, Coovadia and his associates at Harvard and in Austria are convinced they are on the most scientifically valid track.

‘We all lived through the period when formula feeding was quite a disastrous practice and indeed, even now still is. Breastfeeding simply tops the list of interventions available for preventing some of those 11 million deaths of children under 5 globally each year,’ said Coovadia.

One of the most underrated social dangers of the AIDS pandemic in developing countries is that the risk currently inherent in breastfeeding may cause it to go ‘out of fashion’, even among HIV-negative mothers.

‘Breastfeeding is still the best option – almost all the modelling exercises I’ve seen come to the same conclusion,’ he says.

Chris Bateman