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EDITORIAL

When I was asked to write this editorial, on a subject of my choice, it did not take me long to realise that there are no more pressing issues than those surrounding HIV/AIDS. The disease and its impact are so central to our work as physiotherapists and our lives as South Africans that the issues surrounding this disease need to be constantly revisited. The horrifying figures speak for themselves. The 2004 UNAIDS Fact Sheet (UNAIDS/WHO, 2004) reports that in South Africa there are an estimated 5.3 million people infected with the virus and that in 2003, 370 000 people died of AIDS. Consider the enormity of these horrifying figures. **Every day in South Africa, more than 1 000 people die of AIDS.** Can we really conceptualise what these figures mean in terms of human suffering? Do we appreciate the enormity of the disaster or are we suffering from "compassion fatigue"? What can the response of the physiotherapy community be in the face of such an epidemic?

Firstly we need to be well informed, about the virus, the spread of the infection and the prevention and treatment options open to ourselves, our friends, colleagues and patients. The reports by the Medical Research Council (Dorrington et al 2001; Bradshaw et al 2004) and the Human Sciences Research Council (Shishana and Simbayi, 2002) of South Africa provide in-depth information on the changing epidemiology and the progress of the epidemic. There is a constant stream of articles on all aspects of the disease, including behavioural, physical and pharmaceutical interventions published in easily accessible, on-line journals such as the Lancet or the Bulletin of the World Health Organisation.

Secondly, physiotherapists need to be working on developing strategies of intervention that can ameliorate the effects of the disease. There is evidence, for example, that progressive resistance exercise, can help to increase strength, fitness and psychological well being in medically stable patients (Mars, 2004). In this issue of the Journal, we have an excellent article by Potterton and Van Aswegen on the effect of the virus on children. But there are many unanswered questions. We know that infected children

demonstrate considerably delayed milestones. How will paediatric therapists address this problem? Research into intervention is increasingly urgent as these children approach school going age.

We, as therapists, need to actively support all initiatives that aim to reduce the impact of this virus. I suggest we promote a life-long continuum of prevention and care. We should become involved in prevention and health promotion regarding the need for voluntary testing and counselling, the treatment of sexually transmitted diseases and encourage enrolment in the prevention of maternal to child transmission programmes. For children infected with the virus, therapists should institute programmes to identify and stimulate those children with developmental delay and, of course treat any opportunistic infections amenable to physiotherapy. In order to delay the onset of Stage 2 and 3 of the disease, therapists should become involved in activities such as fitness classes; encourage good nutrition and promoting a healthy lifestyle. Once the disease has taken hold, therapists should be involved in treating the impairments resulting from opportunistic diseases and the virus itself and encouraging function. Therapists could have an important role to play in teaching home carers how to manage severely debilitated patients at home, particularly with regard to lifting, transfers and bed mobility.

Thirdly, therapists should be playing an active part in the public discourse around treatment and human rights issues. The polarisation between the Treatment Action Campaign and the Ministry of Health around issues of intervention, particularly anti-retroviral therapy, has been very unhelpful. While the provision of Anti-retroviral (ARV) therapy clearly does prolong life and is cost-effective (Venter, 2005), the major costs are not only related to the drugs themselves, but to the counselling and testing for the virus, testing for side-effects and constant surveillance of compliance. In 2003, the cost of providing ARV to all in need would have increased the health budget from 3.7% to 5.4% of GNP⁶ (Decosas 2003).

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All articles must be submitted in an electronic format directly to the Editor:

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