

Scaling up AIDS treatment in Africa: issues and challenges

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About CHGA

Under the Chairmanship of the Executive Secretary of the Economic Commission for Africa (ECA), K. Y. Amoako, the Commission on HIV/AIDS and Governance in Africa represents the first occasion on which the continent most affected by HIV/AIDS will lead an effort to examine the epidemic in all its aspects and likely future implications. The challenge for CHGA is to provide the data, clarify the nature of the choices facing African governments today, and help consolidate the design and implementation of policies and programmes that can help contain the pandemic in order to support development and foster good governance.

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Abstract

Until recently, the option of treatment for the majority of people living with HIV/AIDS in Africa had seemed impossible: high costs, demanding treatment regimes and the lack of even basic health infrastructure in many heavily affected countries were all cited as potential insurmountable barriers. Today, the prospect of increasing resources coupled with the decreasing costs of treatment and the emergence of simpler treatment regimes, provides an opportunity to scale up national AIDS treatment and care responses in resource-limited settings. The priority is now for African countries to scale up from existing small projects to comprehensive treatment programmes.

Despite these advances, many challenges stay in the way of scaling up AIDS treatment within African contexts. First, there are challenges related to the limited capacity of health systems, such as the low and declining number of health professionals, high drug prices, long-term financial sustainability, inadequate laboratory and patient care infrastructure, poor patient follow up, and sustainability of drug supply. Second, scaling up treatment also requires fostering stakeholder buy-in on all fronts: involvement by the private sector, NGOs, FBOs and communities, as well as ensuring equitable access to treatment and care and overcoming stigma. The aim of this paper is twofold: first, to conceptualize the scope and intensity of recent opportunities for AIDS treatment and care; and second, to highlight some of the major challenges faced by African governments in scaling up programmes for treating and caring for people living with HIV/AIDS.

Introduction

In 2004, it is estimated that 25 million people live with HIV/AIDS in Sub-Saharan Africa, and the number is increasing rapidly. As well as a harrowing catalogue of lives lost, the implications of this human tragedy reach into the structure of economies, the capacity of institutions, the integrity of communities and the viability of families. In the extreme, the survival of some states may well be called into question. Already, communities across large parts of the continent are facing a day-to-day reality of declining standards of living, reduced capacities for personal and social achievement, and an increasingly uncertain future.

While prevention undoubtedly plays an important role in stemming the epidemic, supporting those already infected in living healthier, longer lives is crucial to minimizing the impact of the epidemic, and the two need to advance in parallel. Until recently, life-prolonging treatment was available only to a tiny fraction of HIV-positive people in Africa. High costs, a demanding treatment regime and the lack of even a basic health infrastructure to deliver the treatment were cited as insurmountable barriers to providing treatment to Africans who needed it.

Over the last two to three years, this perception has gradually changed. Four interrelated developments have helped to change this perception:

1. The emergence of a simpler treatment regime

In 1998, the typical daily intake for an individual on antiretrovirals was between six and fifteen pills per day. Today, it can be as little as between two and three per day, as drug makers, particularly producers of generics, have been able to combine several pills into one.

2. The dramatic drop in the cost of ARVs

When ARVs were introduced in the early 1990s, they were hugely expensive. Since then, they have dropped. In the last few years, the price of treatment – in particular first-line treatment – has fallen very quickly, from around US\$10,000 to US\$ 200 per patient per year. Although still beyond the price reach of ordinary people, the general trend is for ARV prices to decline further. This remarkable

achievement is a result of a complex process combining negotiations between the major pharmaceutical companies, UN organizations, governments, NGOs and competition from generic producers.

3. Agreement on a medical treatment protocol for resource-limited settings

Over the past three or so years at least a dozen pilot treatment programmes implemented by numerous actors have helped develop and form consensus around an appropriate treatment protocol for resource limited settings. Although there are still some medical issues to be further improved and clarified, – such as pediatric treatment protocols, the usefulness of structured treatment interruptions, and the efficacy of immune boosters such as vitamins - the general results from the existing pilot studies are very encouraging. Crucially, they show that adherence and treatment results are equal to those in the developed world.

4. Increased international funding for Anti-Retroviral Treatment (ART) for low-income countries.

In June 2001, a watershed was reached when the United Nations General Assembly Special Session (UNGASS) on HIV/AIDS unanimously adopted a Declaration of Commitment recognizing the need for implementing national strategies to address factors affecting the provision of HIV-related drugs. The creation of the Global Fund to fight AIDS, Tuberculosis and Malaria has been a significant indicator of the international commitment for financial support for health related issues in Africa. Among numerous other players on the international scene, the World Bank, the Bill and Melinda Gates Foundation and President Bush's initiative are devoting significant resources to the cause of AIDS treatment in Africa.

As a result of these crucial developments, the international climate of opinion has now shifted firmly in favor of sharply expanding HIV/AIDS treatment in Africa. In 2002, the World Health Organization, along with other UN agencies committed themselves to the goal of providing access to ART for 3 million people before the end of 2005. In addition, African governments have increased their own commitment to fighting the epidemic, including through provision of treatment.

Challenges to scaling up treatment in Africa

Progress in scaling up has not kept pace with increasing demands for HIV-related treatment. It is estimated that only 400,000 HIV-infected persons in the developing countries currently receive ARVs of any kind – about half of them in Brazil alone. The World Health Organization estimates that there are currently 100,000 people on antiretroviral therapy (ART) in Sub-Saharan Africa, a coverage of only 2%, whilst over 4.4 million people remain in need of immediate treatment on the continent. The first funding commitments by the Global Fund made in 2002 has allow a two-fold increase in the total number of individuals receiving ART in developing countries, and a six-fold increase in Africa in the last few years.

In spite of the noted advances, the challenge of scaling up from current initiatives to the comprehensive treatment programmes needed in Africa will pose significant logistical and support problems. Challenges to scaling up HIV-related treatment in Africa can be broadly grouped into two categories: Challenges related to limited health system and other limited structural capacities in most African countries, and challenges related to what is here termed stakeholder buy-in: commitment from the range of key stakeholders that need to be involved to ensure successful increased treatment uptake.

Health System Capacity

In the African context, limited human as well as financial resources in poorly developed health care infrastructures represent major barriers to scaling up treatment provision. The main barriers are:

a. Human Capacity: Low and declining number of health professionals

An immediate imperative is to stabilize and replenish the existing human resource base that provides health care in Africa. In many countries, that base is under siege. Health providers themselves are getting sick at high rates, and many who are healthy are migrating out in search of economic betterment. Furthermore, ART requires close supervision and monitoring of the patient compliance to treatment. This requires substantial work-time from medical staff.

There is a clear need to train more doctors, nurses and other health personnel, but also to improve motivation, working environments and incentives. Tackling issues such as low remuneration and poor benefits, insufficient infrastructure, and lack of opportunities for career development, is a prime challenge in preventing

migration of health professionals and improving an enabling environment for AIDS treatment and care.

Pilot projects have shown that some tasks related to ART such as routine follow-ups and counseling can be carried out by lay community workers, properly trained and supported by referral systems. Scaling up ART therefore also poses the challenge of training and managing more community workers to ease the burden of medical personnel.

b. Financial Capacity: Cost reductions and fiscal sustainability

Costs of ARV drugs have declined substantially, but the price is still prohibitive for most Africans. Take the example of Kenya, where even under the best-case scenario of ARV drugs becoming available at \$1 per day, they would cost 100% of the average monthly income of \$30. At the national level, treating 25% of all HIV infected individuals in Kenya would cost 6.3% of GNP, more than seven times the current government spending on health. For scaling up to be successful, the price of ART and related interventions will need to come down to the level where African governments can budget for them in a sustainable manner.

A number of recent international initiatives provide funding for scaling up AIDS treatment in Africa. Key initiatives for AIDS treatment in Africa such as the Global Fund for AIDS, Tuberculosis and Malaria, the Bill and Melinda Gates Foundation and President Bush's AIDS Initiative represent very positive developments, but have a limited life span. A challenge for governments is that once started, ART must to be provided for the patient's lifetime. When the international funding dries up, governments need to find a way to foot the bill. Improving sustainability and predictability of funds is therefore key to ensuring life-long access treatment. Governments are also faced with the challenge to reduce dependency on external funding by increasing domestic resources and investing donors' resources in capital rather than recurrent costs.

Another challenge for a number of African governments is to increase absorptive capacity to appropriately funnel the additional funding through the public expenditure framework. A major obstacle to this is posed by maximum levels (or 'ceilings') on public spending imposed by international financial institutions such as the International Monetary Fund (IMF), in order to safeguard macroeconomic stability. As a result, countries have found themselves unable to accept additional funding for HIV/AIDS. This issue needs to be addressed in a consistent manner. In addition, governments are required to expand their absorptive capacity to enable utilization of increasing external funds for health.

In any case, cost considerations of treatment should not hinder the promotion of treatment. The provision of treatment is, ultimately, a cost-saving strategy. The benefits of providing treatment through averted hospitalization costs, the social benefits in terms of maintaining household cohesion and saving children from orphanhood, and the economic benefits of maintaining the workforce, are estimated to exceed the financial costs of providing treatment by far.

c. Inadequate laboratory and patient care infrastructure

ART is a complex process which requires close surveillance by care providers, careful adherence to the therapeutic regime, and access to laboratory facilities for continual testing so that the therapy regime can be adjusted. All of these facilities must be available if ART programmes are to be undertaken successfully. In a recent Kenyan study, for example, it was shown that whilst doctors throughout the country were prescribing antiretroviral drugs, only 30% of these doctors had received any training in administering and monitoring ART, and outside Nairobi, no laboratory facilities were available for monitoring the progress of therapy.

d. Poor patient follow-up leading to low adherence

Patients must take ARVs on a regular basis. If random interruptions occur, the virus is likely to mutate into drug-resistant strains. Lack of adherence to treatment is not a new problem. For example, the emergence of multi-drug resistant tuberculosis (TB) is related to lack of adherence to TB treatment. ART, as a life-long, complex and time-demanding treatment, complicates adherence. This is compounded by the stigma surrounding AIDS, forcing some patients to follow the treatment secretly. Close patient follow-up has shown to increase adherence, but this is a challenge in resource-constrained African settings.

e. Sustainable drug supply

A discontinuation in drug supply increases the risk of treatment failure. This is not only detrimental to the patient, but also facilitates the emergence of drug resistant strains of the virus. Periodic drug shortages are not uncommon in Africa, as for example the shortages denounced by MSF and WHO in Kenya in 2003. The challenge at the national level is to build strong drug procurement and distribution systems, avoiding supply interruptions as well as leakages of drugs, and ensuring drug quality. At the project level, logistics are also crucial, including mechanisms to ensure safe drug storage and distribution.

Fostering Stakeholder Buy-in

Successful scaling up of treatment does not only require adequate health care infrastructure, but also commitment and leadership at all levels.

a. Private sector, NGO and FBO involvement

Currently, both the private sector, NGOs and Faith-Based Organisations (FBOs) (including mission hospitals) have been in the front line of treatment provision in Sub-Saharan Africa. As ART is increasingly also made available through public health care systems, efficient coordination and harnessing of the whole spectrum of providers will be crucial. The growing role of the private sector calls for stronger regulation by the government in order to ensure quality and equity of services.

b. Community involvement

Community involvement is crucial to scaling up treatment, for three main reasons. First, communities are instrumental in fighting against stigma and advocating for treatment. Second, their involvement is key in identifying eligibility criteria for treatment. Third, communities are also required to care and support for the infected individuals and affected families. Already strained by multiple demands, communities in the hardest-hit areas are struggling to cope.

More research needs to be devoted to finding out how best to equip communities and maximize their capacity to address these challenges while maintaining community cohesion. A key question is how to ensure active engagement at all levels of the process, ensuring that growing responsibilities are accompanied with the necessary tools and resources for implementation.

c. Ensuring equitable access to treatment and care

Access to treatment and care is a human right. However, in contexts where the need for treatment exceeds the available supply, health care providers have to tackle the difficult question of who gets access to life-saving services and why. For example, in the context of wide-spread gender discrimination, more men than women would be able to access treatment in the absence of intervention to ensure more equitable service distribution.

Human rights, law and ethics provide guidance to expanding services in a just and equitable manner. Principles of utility, efficiency, fairness and sustainability

need to be incorporated and balanced on a case-by-case basis. Involving stakeholders has emerged as a way to facilitate transparent decision-making processes. Experience on prioritization in resource-limited settings is evolving. Botswana, for example, first targets patients with tuberculosis, and HIV-positive women and their spouses and infants. Medecins Sans Frontieres (MSF) in South Africa establishes eligibility based on biomedical adherence and social criteria.

d. Need to overcome stigma.

One of the first lessons from the “Masa” programme in Botswana is that significantly fewer people than expected were coming forward for testing despite the availability of free treatment. Furthermore, many of those who came were in the very advanced stages of the disease, when the ART failure rates are higher. Misinformation, stigma and fear of discrimination are probably key factors discouraging people to come forward for testing and treatment. Much more therefore needs to be done to overcome the cultural constraints to treatment.

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