Antiretroviral treatment in developing countries: the peril of neglecting private providers

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Increased access to antiretroviral drugs is vital to maintain developing countries with high rates of HIV infection. But unless treatment is properly controlled, these drugs could rapidly become useless

See also editorial by Ammann

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Only 5% of the 5.5 million people in developing countries who need antiretroviral treatment currently receive it.[1] New initiatives and global partnerships are trying to increase access to antiretroviral drugs— for example, the International HIV Treatment Access Coalition,[1] guidelines for scaling up antiretroviral treatment,[2] and employee programmes under the umbrella of the Global Business Coalition on HIV/AIDS. However, these initiatives largely ignore the fact that most poor people who suspect they have a sexually transmitted infection seek care in the private sector because of the stigma attached.[3 4] The main care providers for HIV disease in the poorest countries are therefore likely to be private medical practitioners, pharmacists, and traditional and informal providers, such as drug vendors, who are often unregulated and dispense drugs illegally.[4 5] Improper use of antiretroviral drugs may result in development of resistant HIV, so it is important to take account of private providers and regulate their behaviour.

Dangers of unregulated prescribing

Although recent reductions in the price of these drugs are welcome, the rapid increase in legal distribution will inevitably increase illegal leakage into the private sector. Evidence of uncontrolled use is already emerging in the formal and, more worryingly, informal private sector. A study from Zimbabwe in 2000 reported that a quarter of 68 private physicians were prescribing antiretroviral drugs and a quarter of 80 pharmacies were dispensing them to patients, although insurance companies did not reimburse for their use.[6] The authors described prescribing practices as "therapeutic anarchy," with prescribers and dispensers using "any ARV that they could lay their hands on."[6] Monotherapy, stocked by 82% of pharmacies, was prescribed to 17% of patients; and most of the 92 patients interviewed believed that antiretroviral drugs cured HIV infection.[6]

A survey of 21 Ugandan private medical facilities reported that only four of 17 facilities prescribing antiretroviral drugs had received CD4 and viral load results in the previous two months—for 38 of the 340 patients they were monitoring.[7] Tests cost $150-$165 (£100-£110) per sample. Providers had to change patients' treatments because of differences in drug costs and running out of stock. Alternative sources of antiretroviral drugs were "mainly drug donations from relatives abroad and local pharmacies."[7] Of 200 HIV positive patients referred to specialist centres in India because of poor response to antiretroviral treatment, only 10% had adhered to treatment; 50% had stopped taking the drugs on the advice of traditional healers, and 80% had been receiving incorrect doses.[8] In India, 60-85% of primary care provision occurs in the largely unregulated, formal and informal private sector.[5]

In Senegal, nine antiretroviral drugs were available in the informal private sector by 2002, all donations from northern countries that were sold on.[9] The study reported monotherapy, dual therapy, and intermittent treatment, stating that "the patient demand is still very weak, but several sellers in the informal market confirm that they are about to develop marketing strategies to encourage their sale."[9]

Policy makers cannot afford to await conclusive evidence that private providers will soon be at the forefront of providing antiretroviral drugs in developing countries and that their treatment practices will accelerate HIV resistance to these drugs. Private

Sign from private clinic in Phnom Penh, Cambodia

providers are recognised to dominate the market in the treatment of sexually transmitted diseases.[3] However, international and national policy makers have not acted on the available evidence.[10]

Working with the private sector

The public sector needs to learn to compete more effectively in delivering acceptable and high quality services for controlling HIV. Even when users recognise (correctly) that public sector services are technically superior, they choose private providers to minimise stigma.[11] The public sector may therefore be the best channel for delivering short course antiretroviral drugs to prevent mother to child transmission. Trusted private providers, like community health workers,[12] may have greater potential for providing continuity of care and supporting treatment,[13] driven partly by the economic incentive to retain client loyalty. They are an untapped potential for ensuring long term compliance.

Donors need to be more active in helping countries to fulfil their stewardship responsibilities in setting prescribing and dispensing rules (regulation), ensuring compliance (enforcement), and "exercising intelligence and sharing knowledge," to deal with this private sector.[14] Lack of treatment guidelines, but crucially lack of links between private practitioners and specialists and lack of access to research evidence, were reported in Zimbabwe.[6] If guidelines are to contribute to a public health approach,[2] they need to take into account public health realities in resource limited settings. Most poor countries lack two proved essentials for working with dominant and uncontrolled private sectors: financial leverage and effective enforcement of regulatory controls.[5] Additional strategies are needed.

Creating policies for treatment

National policies need to take account of the coverage achieved by different types of providers and the profile of people that providers are serving.[4] Quality of care is determined by providers' knowledge, skills, and access to resources; the influence of user demand (for accessible, acceptable, and short courses of treatment); and policies and practices for drug licensing, importation, and distribution.[5] The problem facing poor countries is that poor people are more likely to use informal providers such as drug shops and vendors as they lack other affordable options.[4]

Policy choices will be difficult. The practices of many private providers are contrary to current policy and hard to monitor. There will be opposition from powerful professional groups to working with informal providers, and projects successful in working with unorganised individual providers are hugely resource intensive.[5] Consequently, working with the more organised formal private sector—doctors, nurses, and trained pharmacists—is the most feasible starting point for governments. No single approach will suffice for all contexts. In settings with low public sector capacity, governments could use non-governmental organisations to run services to control HIV and manage strategies for working with and monitoring private providers.

The public sector also needs to learn the skills of the corporate private sector in social marketing, franchising, and accreditation of provider networks. Much attention is justifiably given to the potential of companies to provide antiretroviral drugs to employees and their families. A model that combines several elements of good practice is the Direct AIDS Intervention Program, a partnership between a company, a non-governmental organisation, and a health maintenance organisation in South Africa.[15] Employees and their families are eligible to receive a free HIV care package including antiretroviral drugs. They can use any of the eligible private practitioners, who are supported by a team of HIV/AIDS medical specialists. However, the poorest people most at risk are not in formal employment.

Cooperation

Drug development, especially for antiretrovirals, is an uncertain and risky venture. It is in the interest of pharmaceutical manufacturers as well as the public sector that prescribing, dispensing, and adherence to treatment are optimal in order to delay the emergence of resistant HIV. Pharmaceutical distributors have sophisticated strategies for monitoring and influencing prescribing practices, even in resource poor settings.[16] They could place these at the service of the public sector.

The goal of an AIDS-free world is too important to risk failure through ideological disputes over public or private sector approaches at the local or global level. Each can learn from the other, and the state should be the guarantor of quality, wherever people seek care.[14] A sustained increase in resources to ensure access to antiretroviral drugs through long term commitments to the Global Fund to Fight AIDS, Tuberculosis, and Malaria; investment in building public sector capacity to manage increasingly complex health systems; and the piloting and evaluation of innovative strategies for delivering antiretroviral drugs are all needed.

At the 14th international conference on AIDS in 2002, Nelson Mandela talked about the window of hope offered by even a few years of additional life on antiretroviral drugs for people with HIV and AIDS. Accelerated HIV resistance due to widespread uncontrolled use in the private sector will remove that hope

Summary points

Action is underway to increase access to antiretroviral drugs, especially in countries with high rates of HIV

The role of private providers is largely ignored, although they are an important source of care for stigmatising diseases in many poor countries

Evidence is emerging that antiretroviral drugs are leaking into formal and informal private markets

Uncontrolled use of drugs in the private sector will lead to rapid development of HIV resistance

Countries require guidance and support from international policy makers and pharmaceutical companies to implement strategies for working with private providers

and threaten populations in poor and wealthy countries alike.

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Back to basics in HIV prevention: focus on exposure

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Despite worldwide efforts to prevent HIV infection, the number of people affected continues to rise. The authors of this article argue that a commonsense approach based on simple country by country analyses could improve the situation

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Every year, the United Nations releases new estimates of the number of people living with HIV infection. Despite 20 years of experience with prevention programmes, this number continues to rise. To date, around 60 million people have been infected with this preventable, fatal viral infection—a sad indictment of the world's prevention efforts so far.[1]

Why have we not done better? Some people suggest that we have focused too much on the behaviours that spread the virus, rather than on the social and economic conditions that promote such behaviours.[2] We believe, rather, that many countries are failing because they are not paying enough attention to who is becoming infected and how. Plans for prevention are often built on broad categorisations of type of epidemic rather than on a careful analysis of where new infections are occurring.

Countries do need to tackle the structural factors that support risky behaviour. Structural change takes time, however, so even this work must be focused on the factors that are most likely to enable people in a particular country to reduce their exposure to HIV. Almost all new HIV infections occur when an infected person shares body fluids with an uninfected person, so prevention programmes must focus on situations in which this is happening.[3 4] This should be obvious, but many countries are being sold "off the peg" prevention packages based on arbitrary numerical thresholds: "If HIV is over

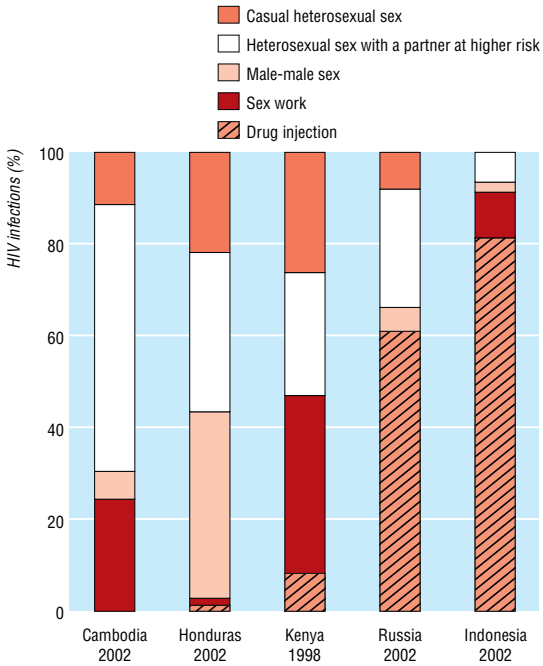

Fig 1 Distribution of new HIV infections by type of exposure in selected countries, 1998-2002. Data on behaviour and HIV prevalence drawn from references 7-17