

HAART is here: What next?

The advent of Highly Active Anti-Retroviral Therapy (HAART) changed the course of AIDS but its availability remains limited in many poor countries. Thus far, only about 100 or so patients receive Antiretrovirals (ARVs) in Pakistan either by out of pocket payments or NGO support (at Rs 2000 to 60000 monthly). This is changing as ARVs imported by the National AIDS Control Program (NACP) with a Global Fund grant have now arrived and the government has agreed upon the policy to allow importation of ARVs. Local manufacturing of ARVs will further relieve these pressures in 2006. However, this good news comes with some unique problems.

Despite increased availability, the supply of ARVs remains limited. The initial consignment of ARVs is for 400 patients only and will be provided at no cost to patients (average procurement cost is US\$ 500-800 per patient annually). While the supply will increase to about 1000 patients in 4 years, plus some more will be available from other sources, a conservative estimate puts the current requirement at about 2000 to perhaps over 10,000. Provisions for testing for CD4 counts and viral loads are also being made but will be limited. Surely there will be a need to triage patients for care.

Triaging happens often in most civic situations although consciously doing so for life saving medicines has already started many heated discussions. As the Pakistani HIV epidemic is fuelled by a very high prevalence among Injecting Drug Users, it seems appealing to provide them with ARVs since successful HAART is the best way to curtail transmission. However, the worldwide experience shows nearly unanimously that active drug users do not benefit from HAART. The other contentious issue will be whether to provide ARVs and services free of charge to all patients or, if those who can afford them should pay part or all of their costs. What systems will insure that this affordability assessment is equitable?

Currently, there are only a few Infectious Diseases (ID)/HIV care trained doctors in Pakistan, all of whom are located in a few large cities. While many patients also live in cities, a significant number are from rural and remote areas. Restricting HIV care to ID physicians essentially restricts HIV care to these cities and is undesirable. For equitable access, it will be necessary to train internists in HIV care. Most Infectious Diseases physicians train for years in HIV care. Condensing that training into a few weeks is asking much and requires a balance between idealism and pragmatism. In the summer of 2005, four internists were trained for 6 weeks in India under NACP sponsorship. When they start treating patients they are sure to face some of the same problems that many of us did in our early training, only they will do it without the benefit of senior clinician supervision that is a part of an ID fellowship. Creative ways to liaison these physicians with ID specialists are needed. One possibility is for ID specialists to act as senior partners providing remote (including on the phone and email) consultations to internists. The logistics and the structure of these consultations and how they fit in the usual practice of the ID specialists remains to be worked out.

In developed countries primary care providers provide much of the preventive and basic health services and refer specific AIDS management to HIV specialists. This concept of primary care is rudimentary in Pakistan and general practitioners do not provide primary care or preventive services. While many HIV patients will require ARVs and other specialty care, a larger proportion is relatively healthy, requiring no more than occasional well visit or counseling. Asking the few trained physicians to care for all needs of all HIV patients rather than to concentrate on AIDS management puts undue burden on them. In developing countries this role is played by other persons living with HIV/AIDS (PLWHA) or community organizations. Pakistan needs to strengthen these institutions which are still in early phase of development.

Finally, the training of doctors is clinic/ hospital based. There is a need to re-think our paradigms since much of HIV care is done outside the hospitals. Indeed the most successful models of care are those that incorporate a continuum from clinic to hospital to home and community. Most doctors are not familiar with these programs. There is a need to meet and work with community activists and PLWHA advocates in order to enhance adherence, ensure patients understand care issues, provide counseling etc.

Treating HIV in developing countries is difficult. Cost and infrastructure constraints are daunting and problems with adherence are compounded by the effects of poverty. On the other hand we are fortunate that active work in HIV in Pakistan has started relatively early. This allows for time to learn from our own and other experiences. Among the challenges and opportunities, our world is what we make of it. For all of us it will be worthwhile to reflect on the way ahead, to apply what we know, learn from other developing countries and above all, improvise when needed.

Adnan A. Khan, MD, MS.
Consultant HIV, STIs and Infectious Diseases
The National AIDS Control Program, NIH
Chak Shahzad, Islamabad, Pakistan
Email: adnan@khans.org
Phone: +92 (51) 925-5368