My Africa

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Who Accesses Antiretroviral Drugs within Public Sector in Malawi?

Malawi is among the countries in southern Africa heavily affected by the pandemic of human immunodeficiency virus (HIV) infection and acquired immunodeficiency syndrome (AIDS). The National AIDS Commission estimates that at least 10% of the adult Malawi population is infected by HIV (1). HIV has resulted in an estimated 800 000 orphans, a resurgence of tuberculosis, and increase in incidence of Kaposi's sarcoma, cryptococcal meningitis, and non-typhoidal salmonellosis (2-5). Maternal mortality ratio, estimated at about 620 deaths per 100 000 live births in 1992 has almost doubled, partly as a result of the HIV/AIDS scourge (6).

Malawi has received the Global Funds to fight AIDS, tuberculosis, and malaria, with 5-year funding totaling US$196 million for HIV/AIDS and the first disbursement received in June 2003. The support is intended for training materials development, small grants to community organizations, voluntary counseling and testing, prevention of mother-to-child HIV transmission, community home-based care including orphan care and support, management of opportunistic infections, strengthening of hospital laboratory services and Central Medical Stores, and financial management and institutional support to the National AIDS Commission. Procurement of medical supplies and other equipment and antiretroviral therapy (ART) roll-out to ensure nationwide access to antiretroviral therapy has also been planned to benefit from the Global Fund money (7,8).

Malawi has adapted the World Health Organization's (WHO) clinical guidelines for ART (9). However, in a situation where at least 150 000 individuals meet the clinical criteria for ART and the public health system can cover medications only for 50 000, the need for equitable social criteria cannot be overemphasized. The opinion of the community on how to ensure equitability in free access to ART was an important part of implementing the guidelines, as well as the community opinion on free vs cost-sharing approach to ART.

Therefore, in 2004, a qualitative research into the public opinion on equitable ART access was conducted using focus group discussions and radio phone-in programs. The public was called upon to suggest what would be the proper way of distributing ART, who should have access to it, and whether ART should be provided at no cost or at subsidized rates (10,11).

Who should have free access to ART?

Considering that the public sector in Malawi was about to offer ART to only 50 000 of 150 000 HIV-infected people who might

benefit from ART over a 5-year period, the question was who should receive ART. The WHO clinical criteria had already been accepted and equitable social criteria for ART access had to be decided upon. Some respondents suggested that children infected with HIV should be given the priority. However, this view was not shared by many. More people indicated that saving the lives of children and letting their parents die from AIDS at the same time would only result in high number of orphans.

Taking occupation as a criterion for free ART access was suggested. The military, police, teachers, and health care professionals were chosen as social groups who should be given priority, because they were most important for the development and functioning of the country. In addition, teachers and health professionals were mostly underpaid. Most respondents suggested that women, especially pregnant ones, should be given priority. Short-term prepartum therapy could prevent mother-to-child transmission of HIV, but again, concerns were raised about having a generation of HIV-free orphans. Some people thought that rural population should have priority in free ART access because it mostly consists of subsistence farmers, who can hardly afford to pay for the medications. Population living in urban areas at least has a regular monthly salary from which they can pay for ART. There was also a feeling that people who publicly disclosed their HIV status should receive priority as a "reward," but also as "encouragement for others to disclose their HIV status, which is good."

Should ART be subsidized?

Since only a fraction of the HIV-infected persons would have access to ART if ART was offered totally free of charge, the community was asked whether any cost-sharing measure ought to be introduced. At the time of the consultation, a month's supply of first-line regimen using Triomune® (stavudine, lamividine, and nevirapine) in the public sector cost about US$24 per patient. All respondents said that ART was unaffordable at that price to the majority of patients in Malawi. However, opinions on cost-sharing differed. Some opposed the very idea of introducing a fee, saying that the terms of ART dispensing, ie, free access, must have been stipulated in the country's request for the Global Fund. Others suggested that providing ART at a cost to the patient would create a black market for these drugs. On the other hand, if these medicines were provided for free, there would be no incentive to steal these medicines as no one would buy them.

Some respondents expressed concern about abuse of the drugs if they were given free of charge, ie, that a nominal user-fee on ART should be introduced so that patients would value the service. They suggested a fee between US$48 and US$96 as affordable to many Malawians.

Discussion

Deciding on who should receive free ART in the public health system in Malawi based on social, as opposed to clinical, criteria is a complex matter and unanimous agreement is unlikely to be obtained. Personal interest and diverse perceptions of how HIV/AIDS can be controlled certainly affect one's decision. The opinion that children should receive ART free of charge is based on the belief that children are "innocent victims" of HIV/AIDS. Accordingly, this belief implies that some people with HIV/AIDS are not innocent, ie, that they "deserved" to be infected as a result of their behavior. The criterion of "innocence" is inherently problematic and many people argue that such an attitude is unhelpful. Blaming the HIV infected person has been perceived as counterproductive in the fight against HIV/AIDS (12,13).

HIV/AIDS in Malawi affects diverse occupational groups. A few studies that have been conducted on mortality from chronic illness and tuberculosis (a surrogate marker of the burden of HIV) showed that rates of HIV-infected in-

dividuals are higher among teachers and health care workers than the general population (14,15). In a larger part of sub-Saharan Africa, uniformed forces (the military and police) also have high HIV-infection rates. It can be argued that teachers, health professionals, and uniformed forces can be privileged in free access to ART within the public sector, based on the usefulness of such professions. The shortage of health human resources have been identified as a crucial ingredient that will determine whether ART programs in Africa will fail or succeed. There are also other professions that can be argued as crucial to society. However, substantive or important contribution to the national economy does not give enough ground to warrant or deny free treatment for HIV/AIDS. The age criterion for free ART, ie, to give priority to children, was met with the counterargument that Malawi would become "an orphan state." This has already occurred as it is estimated that the number of orphans in the 11 million population country amounts to 800 000, with more than half of these children orphaned because of HIV/AIDS. Prioritizing children or not prioritizing their parents at the same time raises a moral dilemma and there is no simple answer.

Another option, although not providing entirely equitable way of identifying beneficiaries of free ART in the public health system, is "first come, first served" principle. By this approach, selection based on gender, age, or occupation would potentially be avoided. However, for such an approach to be reasonably equitable, all people should be necessarily informed of such an option. As this is not possible, some people may not access ART for lack of knowledge of such services, which would thereby lead to inequity. Also, those people closest to the health facilities, those with access to transport, or perhaps relatives of health care workers who know of the existence of the ART program, may access the service more readily than other people.

The reasons for introducing cost-sharing measures in the public health sector and the consequences thereof have been described elsewhere (16,17). I believe the consequences of introducing these measures with ART would not be much different and, while being beneficial as a source of extra revenue and making the users value the service, they may have an unwanted effect of reducing the accessibility for the poor and women. Since ART has already been provided for some years in the private and public health care sectors in the country for a fee, completely to abolish the fee may not be the right thing to do. While a standard consumer contribution of between MK500 and MK1000 (US$50-100) has been suggested, it may not be affordable to all. A graded approach based on personal financial means would be better but extremely difficult to implement. A fee reduction in the public sector could encourage ART adherence as drop-out rates in the current programs due to failure to pay for medications are unacceptably high (Magomero K, personal communication).

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References

1 National AIDS Commission. HIV seroprevalence estimates for Malawi 2003. Lilongwe, Malawi: National AIDS Commission; 2004.

2 Doctor HV, Weinreb AA. Estimation of AIDS adult mortality by verbal autopsy in rural Malawi. AIDS. 2003;17:2509-13. Medline:14600523

3 Nathan LM, Nerlander LM, Dixon JR, Ripley RM, Barnabas R, Wholeben BE, et al. Growth, morbidity, and mortality in a cohort of institutionalized HIV-1-infected African children. J Acquir Immune Defic Syndr. 2003;34:237-41. Medline:14526214

4 Lewis DK, Callaghan M, Phiri K, Chipwete J, Kublin JG, Borgstein E, et al. Prevalence and indicators of HIV and AIDS among adults admitted to medical and surgical wards in Blantyre, Malawi. Trans R Soc Trop Med Hyg. 2003;97:91-6. Medline:12886812

5 Harries AD, Chimzizi R, Nyirenda TE, Van Gorkom J, Salaniponi FM. Preventing recurrent tuberculosis in high HIV-1 prevalent areas in sub-Saharan Africa: what are the options

for tuberculosis control programmes? Int J Tuberc Lung Dis. 2003;7:616-22. Medline:12870681

6 Muula AS, Phiri A. Did maternal mortality ratio increase in Malawi between 1992-1998? Review of Malawi Demographic and Health Surveys and other data sources. Trop Doct. 2003;33:182-5. Medline:12870616

7 Poore P. The Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM). Health Policy Plan. 2004;19:52-3. Medline:14679285

8 Muula AS. Ethical and programmatic challenges in antiretroviral scaling-up in Malawi: challenges in meeting the World Health Organization's "Treating 3 million by 2005" initiative goals. Croat Med J. 2004;45:415-21. Medline:15311413

9 Ministry of Health and Population and National AIDS Commission. Treatment of AIDS. Guidelines for the use of antiretroviral therapy in Malawi. Lilongwe, Malawi: National AIDS Commission; 2003.

10 Helman CG. Research in primary care-the qualitative approach. In: Norton PG, Stewart M, Tudiver F, Bass MJ, Dunn E, editors. Primary care research: traditional and innovative approaches. London: Sage Publications; 1991. p. 105-24.

11 Dooley D. Social research method. Englewood Cliffs: Prentice Hall Inc.; 1984.

12 Decosas J. AIDS education is not our only weapon. Family Plan World. 1992;2:4. Medline:12317125

13 Sowell RL, Seals B, Moneyham L, Guillory J, Demi A, Cohen L. Barriers to health-seeking behaviours for women infected with HIV. Nursingconnections. 1996;9:5-17. Medline:9110785

14 Harries AD, Nyirenda TE, Banerjee A, Boeree MJ, Salaniponi FM. Tuberculosis in health care workers in Malawi. Trans R Soc Trop Med Hyg. 1999;93:32-5. Medline:10492785

15 Harries AD, Hargreaves NJ, Gausi F, Kwanjana JH, Salaniponi FM. High death rates in health workers and teachers in Malawi. Trans R Soc Trop Med Hyg. 2002;96:34-7. Medline:11925986

16 Nanda P. Gender dimensions of user fees: implications for women's utilization of health care. Reprod Health Matters. 2002;10:127-34. Medline:12557649

17 Kowalewski M, Mijinja P, Jahn A. Can mothers afford maternal health care costs? User costs of maternity services in rural Tanzania? Afr J Reprod Health. 2002;6:65-73. Medline:12476730