

A hope for the Hopeless
Anti retroviral therapy for the HIV/AIDS infected people in India

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It is almost 25 years since the world heard of a disease called HIV (Human immunodeficiency virus) /AIDS (acquired immunodeficiency Syndrome). Since then it has spread all over the world. In the next few years India will have the largest number of HIV/AIDS patients in the world.

Within three years of describing the disease in 1980, the virus causing the disease was identified. Tests were available to detect the infected persons. Within a period of five years, it was known that this disease is spread only by sex, blood and from mother to child. All these facts were available within five years of describing the disease. Yet there was no hope for the patients suffering from HIV/AIDS as there was no treatment.

In the early days of the pandemic, patients received treatment for opportunistic infections. It improved the quality of life. It did not change the shortened life span of the infected patients. HIV/AIDS patients lived for seven to ten years after acquiring the infections. Advances in early diagnosis and improved treatment did not improve the life span.

Treatment for HIV

Scientists were trying to find a cure for the disease. In 1987 Zidovudine a compound that was discovered twenty years ago was found to be effective against the virus. Patients had a hope that they will be cured. It also stimulated a search for other drugs. Today we have five different classes of drugs that can be used for treatment of the infection.

Zidovudine therapy was used in patients. It was found that it reduced the viral load in the body and increased the CD4 cells. It also improved the quality of life. Patients required fewer hospitalisations. After some time the virus loads increased and the CD4 count decreased and the disease progressed.

In 1990 two drug combinations were used. Their effects were also similar to the single drug. The viral suppression and increase in CD4 counts lasted little longer. In 1995 three drug combinations were used. It improved the CD4 counts and substantially reduced the viral load. This combination of using three drugs to attack the virus is known as 'Highly active antiretroviral therapy' (ARV). Many scientists believed that two years of therapy will cure the patient. The clinical experience betrayed this belief. Today the ARV therapy is for life. Today the regimens have become standardised and there are definite protocols for using the drugs.

Advantages of the treatment

ARV therapy has substantially reduced morbidity and mortality. In 1994, AIDS was leading cause of death among young adults in USA. By 2000, AIDS was not on the first ten causes of death among young adults.

Similarly ARV therapy has reduced the death rate due to HIV in every country where it has been used.

ARV has improved the quality of life of the patients. Unlike other therapies, e.g. renal transplants etc, patients on ARV are active and contribute to the economy of the community. There is substantial benefit to the community, if it can provide ARV for its HIV infected persons. This has led the WHO to launch 3 by 5 initiative. WHO is aiming to provide access to 3 million HIV infected patients by the year 2005. From April 2004 Government of India will provide ARV in some selected government centres but private hospitals are not involved in this programme.

Disadvantages of the treatment

Though patients have a low viral load, they still can transmit the infection. USA has reduced its death rate due to HIV but new infections occur at the same rate. Like all medications, ARV also has side effects. Sometimes the side effects can be serious.

Constraints to implement the ARV programme

Patient adherence to drug regimen is vitally important for the success of the programmes. If patients are irregular with treatment, then the virus becomes resistant to the drugs. Side effects become more common.

Cost of therapy is a major constraint. Today due to efforts of the drug industry and the Government, cost of therapy has become low (Rs.1500 pm.) yet most of our patients cannot afford. Physicians must be trained in the use

of these regimens. Hospitals need to strengthen their outreach programmes and counselling centres to ensure adherence to the drugs by the patients. The therapy is life long. Good relationships need to be built between the patient, physicians, health care teams and the hospitals.

Role of Catholic hospitals

Catholic hospitals are in a unique position to provide ARV therapy for HIV patients in the country. After the Government we have the largest network of health institutions in the country. Many of our health care institutions are already taking care of HIV infected patients. We have Catholic Health Association of India (CHAI) that is coordinating the HIV programs of the catholic hospitals. St. John's Medical College is conducting training programmes for the management of HIV/AIDS. Many institutions are collaborating with the Government agencies to provide treatment for opportunistic infections.

Catholic hospitals need to look at the various ways in which they can provide ARV to their patients. The cost of therapy can be reduced if the hospitals do a centralising purchase from the drug manufacturers. The benefit can be directly passed on to the patient. Negotiations between the manufacturers, government and a central purchasing organisation or a funding agency can bring down the costs further. E.g. Drugs supplied to some of the NGO's are much cheaper than the market or institutional prices. A distribution network for these drugs needs to be evolved.

Laboratory services needed for providing ARV services are very poor. It needs to be strengthened by networking among catholic institutions and sharing of the expertise between the institutions.

Community and social workers are needed for regular follow up of the patients. Personnel in the hospitals need to be trained in handling ARV medications and in managing HIV infected patients.

All these activities need a central coordinating agency. CBCI Health Commission has taken a lead to organise a HIV/AIDS programme to coordinate these activities.

Financial assistance is also necessary. All avenues of financial help needs to be explored. The problem that arises is that most of the donor agencies will provide support for a particular period and then withdraw. We need to make the programmes self sustaining. We need to look at ways of tapping resources locally. During the period of lent, people can be asked to contribute their Lenten alms to help HIV/AIDS patients. People who can afford can be asked to sponsor a patient for treatment for a specified time.

To ensure adherence and ownership by the patients, a token amount not exceeding ten percent of the total cost of the drugs should be levied even if the drugs are provided free of cost by donor agencies. This money can then be used by the hospital to provide drugs when the donor withdraws. Hospitals can evolve policies so that patients who are regular on medications will be offered free treatment for a month or so in a year.

The hospitals will also benefit from providing ARV therapy. They will have a steady group of patients. Expertise that is gained in management of these patients can be used to handle other chronic diseases. It will reduce the stigma for the patients. Serving HIV infected patients will help the Catholic hospitals to realise their mission.