Making HIV programmes work: The Heineken workplace programme to prevent and treat HIV infection 2001-2010

Van der Borght, Stefaan

Citation for published version (APA):

General rights
It is not permitted to download or to forward/distribute the text or part of it without the consent of the author(s) and/or copyright holder(s), other than for strictly personal, individual use, unless the work is under an open content license (like Creative Commons).

Disclaimer/Complaints regulations
If you believe that digital publication of certain material infringes any of your rights or (privacy) interests, please let the Library know, stating your reasons. In case of a legitimate complaint, the Library will make the material inaccessible and/or remove it from the website. Please Ask the Library: http://uba.uva.nl/en/contact, or a letter to: Library of the University of Amsterdam, Secretariat, Singel 425, 1012 WP Amsterdam, The Netherlands. You will be contacted as soon as possible.

UvA-DARE is a service provided by the library of the University of Amsterdam (http://dare.uva.nl)
Chapter 7:

HAART for the HIV-infected employees of large companies in Africa.
Why do large companies not offer treatment to their HIV infected employees in Africa? Eleven wrong arguments.

Stefaan Van der Borght, Tobias Rinke de Wit, Vincent Janssens, Maarten Schim van der Loeff, Henk Rijckborst, Joep Lange.

Heineken International Health Affairs, Vijzelstraat 72, 1017 HL Amsterdam, the Netherlands (Dr S Van der Borght MSc, Dr H Rijckborst); PharmAccess Foundation, Meibergdreef 9 (T-220), PO Box 22700, 1100 DE Amsterdam, the Netherlands. (Prof TF Rinke de Wit PhD, Dr V Janssens, Dr MF Schim van der Loeff, Prof JMA Lange MD); Center of Poverty-related Communicable Diseases, Academic Medical Center, University of Amsterdam, Meibergdreef 9 (T-125), PO Box 22700, 1100 DE Amsterdam, the Netherlands (Prof TF Rinke de Wit PhD, Dr MF Schim van der Loeff, Prof JMA Lange MD).

Corresponding author: Dr S Van der Borght. Heineken International Health Affairs, Vijzelstraat 72, 1017 HL Amsterdam, the Netherlands. Tel. +31-20-5239487. Fax. +31-715457788. Email: S.vanderBorght@heineken.com.

Requests for reprints to Dr S Van der Borght.

Running head: eleven wrong reasons to withhold HAART

Word Count: 2592

Word count abstract: 176

Number of figures: 1

Number of Tables: 0
Abstract
Few large companies operating in sub Saharan Africa offer comprehensive HIV/AIDS programs including Highly Active Anti-Retroviral Treatment (HAART) to HIV infected employees and dependents. From September 2001 onwards Heineken, a multinational brewing company, started to offer HAART to its HIV-infected workers and dependents. In many (business) forums the company was asked to justify that decision. The reverse question: “Why do other companies not offer antiretroviral treatment?” was met by a variety of answers. In this paper we list eleven reasons that have been forwarded by various large companies to deny HAART to their HIV infected workers in resource-limited settings, and point out why they do not hold. Although HAART is complex, it is feasible in resource-limited settings and affordable and sustainable in the setting of large companies. HIV is a justified priority for companies, and prevention alone is not sufficient. Treatment success in Africa is comparable to that found in the West, and even though the infection is not workplace-acquired, treatment should be a large company’s responsibility and not only left to the public sector.

Key words: HIV, antiretroviral treatment; Africa, workplace programmes, drug resistance, private sector
Introduction

The International AIDS Conference held in Durban in the year 2000 was a watershed for Highly Active Anti-Retroviral Treatment (HAART) in Africa. Since the conference, HAART in sub-Saharan Africa is firmly on the international agenda and access to HAART for resource-poor settings has become a top priority. Multiple initiatives were developed to realize this goal (The Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM), The (US) President’s Emergency Plan for AIDS Relief (PEPFAR), the World Bank’s Multi-country AIDS Programme (MAP) and many others). Although private sector employers operating in Africa were amongst the first to embark on HAART for their workers, (Anglo-American, Compagnie Ivoirienne d’Electricité, Volkswagen South Africa e.g.) public sector approaches have now largely surpassed these private sector efforts. To date only few large companies operating in Africa have launched comprehensive AIDS treatment schemes for their workers and dependents. (1-3) The majority of employers in Africa hesitate to take responsibility and basically refer to government HIV programs that are benefiting from international financial support, but struggling with implementation. There is an encouraging trend among companies in high prevalence countries to have HIV policies, but even in countries with prevalences between 5% and 20%, less than 50% of companies claim to have an HIV policy.(1) In sub-Saharan Africa only 26% of the companies that have HIV policies provide antiretroviral treatment to their workers.(1)

In 2001 Heineken, an international brewing company with interests in 170 countries and production sites in 60 countries, decided to add HAART to the package of medical benefits that workers could enjoy. Where the existing medical policy extended to spouses and family members, these dependents would also benefit from this measure.
The programme is implemented in collaboration with PharmAccess Foundation, a Dutch NGO dedicated to sustainable quality AIDS treatment in resource-poor settings.

In many business meetings and forums Heineken was asked what justified the decision to offer treatment to their employees. On those occasions the question was reversed and companies were asked: “why not?” Various reasons were forwarded; the most important ones are listed here and we point out why they are not valid.

Reason 1: HAART is very complicated, difficult to administer and skilled physicians are rare in Africa (4)

Today, more than 20 different antiretroviral medicines are available and new drugs and drug combinations are regularly appearing on the market. The combination of three drugs that are needed for highly active antiretroviral treatment (HAART) is regarded as very complex. Companies argue that expert know-how is needed and that “AIDS is not our core business”.

In 2003 the WHO published guidelines to scale up HAART in resource-limited countries offering simpler protocols and guidelines. (5) Thus, in practice, there are less than 5 combinations of antiretroviral drugs commonly used in Africa. The Heineken Workplace Programme (WPP) chose to use only two of these combinations: a first line regimen consisting of zidovudine/stavudine, lamivudine and efavirenz or nevirapine, and a second line regimen consisting of didanosine, tenofovir and lopinavir/ritonavir.

This restricted HAART regimen choice warranted an efficient transfer of knowledge to Heineken medical staff. In brief, the Heineken WPP treatment teams attended a 3-day theoretical workshop during which the principles of HAART were explained, the eight drugs used in the programme introduced, and drug interactions reviewed. The
theoretical workshop was followed by a practical traineeship of 2-3 weeks, where the
doctors were seeing patients under the supervision of a clinician experienced in
antiretroviral treatment. When the teams started treating patients with ARV’s, bi-
weekly teleconferences were conducted to enable clinical review of the patients. These
teleconferences were supported by an electronic database with key patient data, entered
by the teams in Africa and also accessible from Europe. This tool allowed a team of
experienced clinicians (from PharmAccess Foundation) to assist their colleagues in
Africa in an efficient and affordable manner.

Therefore, with practical HAART choices and targeted clinical support, general
practitioners are able to effectively manage HIV patients, at low additional costs.

**Reason 2: HAART is very expensive**

More than one billion people worldwide including almost half of the population in
Africa have to get by on one dollar a day. (6) AIDS treatment drug costs have
decreased dramatically over the last five years, but these are still at least US$150 per
patient per year for the cheapest drug combination. The costs of laboratory monitoring
are approximately similar (US$ 100/year). Therefore, it is often argued that HAART
remains beyond the financial reach of the great majority of persons living in these
countries, and out-of-pocket payment can cause individuals and families to swiftly fall
below the poverty line. (7) However, in our view it is inappropriate for decision makers
of large companies to use the same argument.

First of all, the costs of several hundred dollars per person per year should be put in the
perspective of the benefits that are raised by a healthy workforce. Secondly,
antiretroviral treatment reduces the need for hospital admissions, as shown both in
developed (8,9) and in developing countries (10,11), leading to substantial cost savings.
Third, workplace AIDS treatment costs have usually been far lower than expected. In
the Heineken Workplace Programme in Rwanda for example, after two years 75 HIV-
seropositive adults were identified amongst 460 persons that participated in the
voluntary counselling and testing (43% of the 1060 target population for the
programme). Of this group only 36 patients (48%) required immediate 1st line
antiretroviral treatment. Over 4 years the number of identified HIV+ patients increased
to 108, of whom 74 are currently on HAART: 66 on 1st line and 8 on 2nd line. Thirty-
four patients are not on HAART, but are monitored by regular CD4 counts.
Figure 1 depicts the cumulative numbers of HIV positives, patients on 1st line HAART
and patients on 2nd line HAART between 2001 and 2006 at the Heineken Rwanda
breweries. Given a cost of $500 for 1st line and $1,500 for 2nd line treatment in the year
2001, decreasing to $150 for 1st line and $1000 for 2nd line in the year 2006, one can
conclude that the actual extra cost of providing HAART has been constant over the
years: approximately $45 per employee per year.
Often companies have asked experts to make cost-benefit analyses concerning
HAART. We feel this is not the right question, and instead they should determine
whether treating workers and their families is affordable in the foreseeable future and
may remain so in the longer term. If cost-benefit arguments are used, segmentation
among employees (management versus staff, skilled versus unskilled workers) will be
considered. This might lead to conclusions that HAART should be provided for skilled
workers but not for unskilled workers.(12) In order to preserve equity among workers
the affordability argument will need to enter the equation.(12). The use of affordability
as a norm is probably more common than the cost-benefit analysis in human resource
decisions (salaries, secondary benefits). The real-life example of the Heineken programme above might help corporate decision makers to make the appropriate choices.

**Reason 3: African patients are not adherent; they lack the discipline to take the drugs at the right time and in the right dosage**

When HAART for Africa was first proposed, fear was expressed that African patients would be less adherent to the daily regimen because of different time and disease concepts.(13) Experience with HAART in Africa so far has shown this fear to be misplaced. Adherence has been good in many different studies across the continent. (14-16) In general, available data do not suggest that adherence in Africa is different from that in Europe or the US. The favourable survival in a recent pooled analysis of various cohorts from developing counties supports this. (17)

**Reason 4: HAART is not sustainable**

Because of the cost of ARV’s and the need for life-long treatment, provision of HAART in resource-limited setting has been regarded as unsustainable. In several of the sub-saharan countries even the basic health care infrastructure is not financially sustainable and relies heavily on donor aid.

If sustainability is seen as the ability of a country to independently raise the financial resources for its health care system, then most of the current HAART programmes in sub-Saharan Africa are indeed not sustainable. However, if sustainability is considered on a global scale (and this is where many large companies operate), these programmes are sustainable.
In addition, many large companies in sub-Saharan Africa have shown to be stable and sustainable entities, having uninterrupted local presence for many decades. If these companies would arrange access to HAART for their workforce, this should be more sustainable than many public programmes that are inspired and hindered by the fickle fashion of the donor community.

In case of retirement or retrenchment of workers companies should either continue provision of ART or arrange for a guided transition of the treated worker to a public treatment programme.

**Reason 5: HIV treatment in Africa will create resistance to antiretroviral drugs and will render them useless**

It has been argued that provision of antiretrovirals in African settings may lead to rapid resistance creation. (4,18) If the virus is resistant to the drugs taken, there will be no full viral suppression and the disease will progress. Second line treatment is more expensive than first line treatment, and has less chance of success than the first regimen.(19) There is the additional risk of transmission of resistant virus, and people infected with resistant virus will not respond well to 1st line treatment.(20)

Development of resistance can be avoided in several ways (adherence, low pill burden, etc.) and corporate programs provide opportunities to do so. Because sub-Saharan Africa has not had a period of extensive mono- or dual therapy like North America or Europe, the resistance problem may be much less than anticipated. In the Heineken programme a strong framework and close monitoring aim to contain the major risk factors for resistance formation. Financial distress leading to drug holidays is avoided by sponsoring HAART; drug-sharing is avoided by entitling registered dependents to treatment; use of counterfeit drugs is avoided by strict procurement rules; discontinuity
of supply is avoided by the presence of buffer stocks of drugs; and incorrect
prescription is avoided by using simple protocols and providing training, feedback, and
supervision. Thus, relatively simple measures at the corporate level have created
optimal conditions for prolonged HAART adherence.

Reason 6: Treatment of employees will increase inequity in society

Some African government officials as well as observers from the West have warned
that HAART programmes sponsored by employers would not be equitable. People
already in a relatively fortunate position (having paid employment) would benefit rather
than the unemployed and the poor. The price of rollout of HAART is increased
inequity, they argue.

. When new treatment or prevention is made available, this has to start somewhere, and
in practice it usually starts in urban areas, and among those who are relatively well
off.(21) That does not mean it will stop there. We feel it is better to start somewhere,
and private companies have the means, the reasons, and the opportunity to start. Good
example leads to following.

In addition, in the African context those who are fortunate enough to have a well-paid
job usually take care of a very large number of dependents. If the income-generator
looses his/her job because of sickness, this has consequences for the entire (extended)
family

Reason 7: HAART is not an appropriate technology for developing countries

Malaria and tuberculosis can be diagnosed by clinical skills and simple tools
(microscopy) and yet these infections are not controlled in sub-Saharan Africa. Many
children in Africa die from vaccine-preventable diseases. In a continent where even straightforward disease control strategies do not succeed, how could one seriously consider to introduce complex disease management strategies like HAART?

The complexity is relative though. Most large companies operating in sub-Saharan Africa equip their African sites with similar infrastructure and capacities as their subsidiaries in OECD countries. Large investments are made in information technology in the private sector in Africa, and these are deemed necessary for the successful operation of the company. In a similar manner companies can invest in health technology for their staff. If complex computer networks and assembly lines can be made operational, surely 3-drug regimens with laboratory monitoring can be made to work as well.

**Reason 8: More people die from malaria and tuberculosis, so these diseases should get priority over HIV.**

For the medical services of a company the desired outcome of a well functioning medical service is to achieve a mortality record comparable to that in middle income and high-income countries. This means that mortality due to infectious diseases should be minimal.

Although malaria, diarrhoeal diseases, measles, and acute respiratory tract infections are major causes of death in sub-Saharan Africa, they mainly affect children. In contrast, tuberculosis and HIV mainly affect adults, especially those in the age groups 18-45 years, the economically and pedagogically most productive period of life for most people. So for companies (but also governments and non-governmental
organisations) in sub-Saharan Africa, HIV and tuberculosis are the biggest threats to the health of their workforce and they should be priorities.

Reason 9: Being infected with HIV is due to an individual’s private behaviour, and therefore no issue for the company

Some people, and indeed some companies, contend that HIV infection, being usually the result of sexual intercourse, is not a workplace-acquired condition and that therefore there is no obligation for the companies to treat their HIV infected employees. This sounds logical, but in fact many diseases of workers are not occupational, and still companies cover the costs of medical treatment (e.g. malaria, tuberculosis, sexually transmitted infections, diabetes and hypertension). Why should HIV be an exception?

Reason 10: Public health is a government’s responsibility

It is the government’s responsibility to protect the health of the citizens, it is often argued; so private companies have no role in their health care. The reality is that in many places governments do not provide adequate health care or preventive services. In that case private companies (or non-governmental organisations) should do what is in the interest of their employees and provide required health care and not hide behind a government’s failure to deliver. This best serves the long-term interests of a company as well.

Reason 11: Prevention is the only way to tackle the HIV epidemic

Treatment cannot be the solution to the HIV epidemic, some argue, and prevention should be centre stage. There are quite some examples of multinational companies operating in Africa, which have comprehensive HIV infection prevention programmes
in place, but do not offer HAART to their workers and dependents.(1) The harsh consequence of this position is that those already infected are left to die. Although prevention efforts are crucial and should be increased, those who are already infected have the right to be treated to avoid a certain and premature death. In addition, prevention programs benefit from simultaneous HAART programs. Trying to choose between prevention and treatment is not helpful.(22)

Conclusions

Providing antiretroviral treatment to workers of large companies in Africa is feasible. Heineken mostly offers health care for its staff through company health services, but the arguments equally apply to companies that offer health care outside company clinics, e.g. through insurance. In the course of the last four years various arguments have been raised by outsiders against Heineken’s workplace programmes. In the above we reviewed eleven such reasons; none of them stand up to scrutiny. Rather than asking Heineken or other companies that provide HAART to their employees: “Why do you do this?” we feel it is time to ask other companies: “When will you start?”
Contributions
S Van der Borght and TF Rinke de Wit had the original ideas. SVDB wrote the first draft. All authors discussed the ideas and commented on drafts in various stages. SVDB, TRdW and M Schim van der Loeff wrote subsequent drafts. All authors read and approved the final version.

Conflict of Interest Statement
S Van der Borght and H Rijckborst are employees of Heineken. TF Rinke de Wit, MF Schim van der Loeff are employees, V Janssens is a former employee and JMA Lange is Board Member of PharmAccess Foundation, an NGO contracted by Heineken to support the workplace programme.

References


Figure 1. HIV detection and treatment at Heineken in Rwanda, 2001-6.

* Statistics over 2001 are from September - December only