Making HIV programmes work: The Heineken workplace programme to prevent and treat HIV infection 2001- 2010
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Chapter 8:

General Discussion
The decision of the Heineken Executive Board in 2001 to start providing antiretrovirals (ARVs) to its workers and their dependents was not an easy one. Those were pre-Global Fund days, and international health policy experts were still discussing whether it would ever be possible to provide ARVs in Africa. Particularly after the 1996 introduction of highly active retroviral therapy (HAART), the costs of the drugs were excessive. Many experts feared that Africans would adhere poorly to ARVs, leading to the development of drug resistance. The apparent need for continuous laboratory monitoring—with expensive tests like CD4 lymphocyte counts and viral load determination—made financial sustainability seem doubtful. Moreover, the many facets of ARV programmes in high-income countries did not fit the African reality and further discouraged the plans for ARV rollout in these settings. The number of HIV-infected people treated locally on the African continent was unknown, but probably not more than a couple of thousand. There was no precedent for large-scale ARV treatment programs in resource-poor settings, and certainly not in the African countries where Heineken operating companies (OPCOs) were based: Democratic Republic of Congo, Republic of Congo, Rwanda, Burundi, Nigeria, Ghana, and Sierra Leone.

Before 2000, Heineken did not see the need to examine in detail the possibility of providing HAART. The costs of the drugs were extremely high compared to usual expenses for a basic health care package; the OPCOs could never afford to provide these drugs. No further exploration on feasibility seemed needed, and no one expected private business to have a role in HIV treatment.

The World AIDS Conference of July 2000 in Durban, South Africa, proved to be a watershed event. Before the conference, a few Indian pharmaceutical companies announced that they would produce cheap, generic antiretroviral drugs. In cooperation with UN agencies, the innovator industry launched, around the same time, the Accelerating Access Initiative (AAI) with the goal of reducing ARV costs in low-income countries to 10% of their cost in high-income countries. The idea that HAART might eventually be possible for $5 per day entirely changed the perspective for Heineken. With the prospect of much lower cost, it became worthwhile to examine the other challenges of a treatment programme.

Heineken’s policy in Africa had traditionally been that OPCOs would provide health care for its employees and dependents whenever there was no other source of local health care. Since such sources are few in Africa, most Heineken OPCOs have been well equipped with a
company clinic that employs a physician, a nurse, and sometimes a lab technologist. With the launch of AAI, the opportunity now arose to expand the existing medical infrastructure of Heineken to provide antiretroviral treatment (ART) for employees and their families. In 2001 the initial adult target population for such an intervention were the seropositives amongst 7,500 employees and 6,000 spouses in the African OPCOs.

An initial discussion was held with the non-governmental organisation (NGO) PharmAccess Foundation who convinced Heineken management to explore the possibilities to start a treatment programme. A multidisciplinary committee was created at Heineken to prepare a policy and to define the contents of a workplace programme (WPP). As in-house healthcare staff required ARV-related knowledge to execute the expanded program, Heineken approached PharmAccess to provide a multi-year technical assistance programme. The Heineken assets—an existing medical infrastructure with sufficient financial means, well-developed human resource systems, and relatively large target populations in several African countries—were considered advantageous by PharmAccess to deliver “proof of principle” for workplace-based treatment programmes in Africa. This is how the Heineken-PharmAccess collaboration started and ultimately developed one of the very first programs in Africa to provide ARV therapy at the workplace.

Today, with over 4 million people on ARVs, of whom 3 million live in Africa (December 2008)\(^1\), the above context has markedly improved. Large public programs are being rolled out in almost every African state, supported by multimillion funds provided by the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM); the World Bank (Multi-country AIDS Programme: MAP); the U.S. President’s Emergency Plan for AIDS Relief (PEPFAR), and foundations like UNITAID. Today, several large companies in sub-Saharan Africa (SSA) include human immunodeficiency virus (HIV) treatment in their standard medical benefit packages.\(^2\,3\)

### 2. Contents of the workplace programme

The Heineken workplace programme (HWPP) in Africa is unusual in that HIV prevention and treatment activities are implemented through its own medical staff. This creates incentives to mobilize the entire company. The 16 sites in Africa have, on average, about 350 employees; thus the local number of infected persons is not very large, and personal follow-up and close supervision are feasible. Routine in-house data
collection proved easier and more affordable than in an outsourced programme. A key step was Heineken's implementation of a multi-country web-based database that allows for patient monitoring and analysis of test and treatment data. The important components of the HWPP are depicted in box 1.

Box 1 provides an overview of the key elements of the Heineken WPP.

**Commitment to non-discrimination.** HIV-infected staff have the same chances for promotion and job development as non-infected staff. All medical data are shielded from the Human Resource (HR) department staff. The HR manager will receive such data only with explicit verbal approval of the employee. Moreover, since 1998, pre-employment testing for HIV is proscribed in the Heineken companies; HIV positivity has no influence on recruitment.

**Dependents have access to the same programme as employees.** From the start, spouses of employees were eligible for ART. Some months after the start of the programme, children of employees were also declared eligible, despite possible problems with availability of paediatric formulations of ARV drugs.

**Treatment is for life.** No interruption in treatment is accepted. Even employees who retire or are asked to leave the company will continue to receive treatment, as long as no similar treatment programme is identified outside the OPCO. Such continuation of treatment is not guaranteed for employees who leave the company by choice.

**Availability of voluntary counselling and testing (VCT) free of charge.** Most of the time VCT is offered in-house. People can attend outside testing centres, but in order to benefit from an OPCO’s free ART, they must report a seropositive status to the OPCO’s medical department.

**Availability of high quality ARVs free of charge for all those that have a medical indication to start treatment.** The Executive Board of Heineken stipulated that Heineken Health Affairs should select the best available treatment options. With the assistance of PharmAccess, the first- and second-line regimens were constantly updated. Initially AAI drugs were used, the available number of generic drugs with prequalification by the World Health Organisation (WHO) has since increased. When prequalified drugs retained for the selected protocol could be obtained locally, preference was given to those drugs.
When active tuberculosis (TB) is diagnosed in HIV-infected patients, the best possible anti-TB treatment is provided. If active TB is excluded, Isoniazid Preventive Therapy (IPT) is given according to the best standards of care to all seropositives, except in countries whose national programmes do not allow IPT.

**Pregnant women are tested for HIV.** Seropositive women are put on HAART if their CD4 count is under 350 cells/µl. In those with a higher CD4 count, prevention of mother-to-child transmission (PMTCT) is provided as tri-therapy during the last trimester of the pregnancy, recently this is even provided from week 14 of the pregnancy, and during breastfeeding. In some instances, bottled water is provided if the mother chooses not to breastfeed.

**Condoms are freely available on the work premises.** Sometimes these are provided by outside social marketing programmes; otherwise, the company buys the condoms for free distribution.

**Diagnosis and treatment of sexually transmitted infections (STI)** uses a syndromic approach. The signs and symptoms of an STI are fed into a flowchart yielding the most likely diagnosis and treatment.

The referral centres in each OPCO area have been checked and selected for the presence of safe blood supply and a practice of safe injections. As much as possible, referrals were limited to centres that can guarantee a safe blood supply and the use of clean needles.

It was decided not only to monitor and evaluate the HWPP but also to perform operational research, with the vision that other WPPs might benefit from Heineken’s experiences. The results would be shared with a wide audience, including the peer-reviewed scientific world. Therefore this thesis is based on scientific publications on HWPP topics that highlight important aspects of the implementation of WPPs in African settings.

### 3. Features of the published papers

During the nine years the HWPP has been running, it has been possible to study some components that are central to the programme’s success. Chapters 2 through 7 of this thesis examined several of those components, which are summarised with their main conclusions in the paragraphs of this section.
Chapter 2 discusses the Accelerating Access Initiative (AAI). This initiative was a groundbreaking cooperation between pharmaceutical firms and UN agencies -- United Nations Population Fund (UNFPA), United Nations Children’s Fund (UNICEF), World Health Organization (WHO), and the Joint United Nations Programme on HIV/AIDS (UNAIDS) -- to improve access to ARVs in poor countries. For Heineken, this was a very important initiative: the price reduction of brand-name ARVs made it possible to plan a workplace-based treatment programme. Although the AAI was key to the Heineken decision to start ART programs, there were multiple bottlenecks and logistical challenges. In particular, consistency of drug supply was cumbersome to maintain for the OPCOs. Every pharmaceutical company had its own separate administrative procedures; importation of drugs by a brewery proved to be difficult; the delivery of drugs was often slow, and sometimes national governments were unhelpful. From the Heineken experience, it is clear that affordable drug prices are an important reason for the private sector to consider starting a workplace ART programme. The recommendations of the paper are that the private sector should have access to discounted ARVs under the AAI; a network should be created to assist in the logistics of drug ordering, purchase and clearance; and governments should abstain from levying import duties on ARVs.

A serious obstacle to providing ART, particularly in the early days, was the absence of adequately trained health care staff. The correct use of ARVs, an emphasis on drug adherence, and proper interpretation of laboratory monitoring results are all critical for treatment success. Additional training and monitoring of Heineken’s health care staff was therefore necessary. For staff who could not be absent from the job for a long training session, initial training was provided in the form of a crash course. Also, it was opted to maintain and extend knowledge during program roll-out on a “learning by doing” basis. To support this approach, a clinical mentoring program, using regular teleconferences, was established in collaboration with PharmAccess. With this tool, as described in Chapter 3, one experienced clinician coaches several practitioners at the same time. Together they discuss clinical issues that appear in day-to-day practice and that lead to additional questions. Easy distant access to the patient files by the experienced clinician has added extra quality to this mentorship. The nature of the most frequently discussed topics was analysed and has helped to determine various knowledge gaps. These gaps were addressed during refresher training sessions that were subsequently organised. Conclusions are that mentoring offers the
possibility to accelerate the implementation of new treatment projects; it avoids the absence from work that would be required by long or distant training sessions. The close monitoring helps clinicians to deal with issues such as ARV toxicity, diagnosis and treatment of TB, and the switch from first- to second-line drugs.

Coverage of Voluntary Counselling and Testing at Heineken, Rwanda

Offering quality care for HIV-1-infected employees and their family members offers the most benefit if infected persons are diagnosed early. VCT is important to diagnosis, although its role in HIV prevention is probably limited. As described in Chapter 4, we followed the VCT activities in the Rwanda OPCO. To ascertain that VCT was indeed diagnosing the HIV-infected workers at the company clinic, a survey using oral transudate swabs was conducted in the adult target population at the Rwandan brewery. The survey produced an estimate of the number of HIV-infected employees; this estimate was compared to the actual number of HIV-infected employees registered at the clinic. It was found that the large majority of HIV-infected employees was already enrolled in the ART programme. Forty months after the start of the programme, the uptake of HIV testing by HIV-infected persons appeared to be good: 73% of employees and 62% of spouses took the test. They accounted for 87% of seropositive adults. A qualitative evaluation was carried out to learn what factors determined the decision to come forward for HIV testing. For employees, inhibitors of testing were the perception or experience of confidentiality breaches and fear of dismissal. Managers cited a fear of losing of status or job position if their HIV status became known. Enablers of testing identified from the qualitative survey were a presentation to employees given by an HIV-positive speaker, the efforts and presentations of the company medical officer, and the availability of treatment. Another key finding is that sick persons report earlier for testing. That is, HIV-positive persons with lower CD4 lymphocyte counts came for testing sooner, once the programme was available, than did those with higher CD4 counts.

Long-Term Uptake of Voluntary Counselling and Testing in the African sites

In Chapter 5, the uptake of VCT by employees and spouses was analysed in all African OPCOs. It was shown that specific mobilisation events and efforts by staff can influence the uptake considerably. This has been shown in other WPPs as well. Uptake of HIV testing differed by employment status (i.e., more uptake by employees than by spouses) rather than by gender. Women in both categories were more likely to get tested than men. The peak
of testing uptake occurred after the first year of the programme, probably because trust in the confidentiality and non-discrimination promises had grown over that year. If the routine uptake results are unsatisfactory, they can be considerably improved by linking and integrating HIV testing with other health care interventions (immunisation, annual check-up, and health education and information campaigns). In the absence of linkage with such interventions, testing uptake can decrease to very low levels. Like the analysis in Rwanda, analysis of all OPCOs showed higher proportions of HIV-infected persons amongst those tested in the early phases of the programme, compared to those tested later. CD4 lymphocyte count was lower among HIV-infected people tested early compared to those tested later, and people coming early in the programme were generally in a more advanced disease stage (according to Centres for Disease Control and Prevention staging) than those coming later. This conclusion is important for programme managers who wish to predict the dynamics of a treatment programme. The proportion of seropositives seen in the early phases will be higher than would be expected based on HIV prevalence in the whole target population.

Mortality and morbidity among HIV-1-infected persons

When the Executive Board of Heineken decided to add HIV treatment to the package of medical benefits, it stipulated explicitly that the programme had to be of good quality. The best indicator for the quality of an HIV treatment programme is the long-term survival of the patients. This was analysed in Chapter 6, and the results of the HWPP are very good compared to other results reported from sub-Saharan Africa (SSA). The mortality rate of patients on ARV treatment was 3.7 per 100 person-years, with a higher mortality during the first 16 weeks of HIV treatment (14 per 100 person-years). In terms of survival: four years after the diagnosis, 89% of the patients were still known to be alive and on HAART. With survival comparable to cohorts in other low-income countries, the programme has lived up to the quality requirement of the Executive Board of Heineken. A cohort in Botswana reported comparable results in mortality but much higher loss to follow-up, which occurred mainly before people were put on HAART (33/431). This phenomenon has also been observed in other cohorts. Once on HAART, the HWPP loss to follow-up was very low (7/249) when compared to long-term retention in other African ARV therapy programmes. An in-house workplace programme provides possibilities for intensive follow-up and tracking of defaulters; communication with colleagues can be used to reduce treatment failure caused by poor adherence. The importance of such communication and readily accessible health services has been described in similar settings.
AIDS-related morbidity is an indicator for the health status of a patient. After starting HAART in the HWPP, the incidence rate for new AIDS-defining events was low (1.9 per 100 person-years). Of the 9 incident cases, 5 were due to TB. Studies in other low-income countries have likewise cited TB as one of the important opportunistic infections.\textsuperscript{15}

For a workplace-based programme, the survival of employees and the maintenance of their health status are the economic drivers. As a conclusion of this chapter, it can be stated that HWPP leads to reduction of mortality and morbidity. From the business point of view, such reduction allows the continuation of a productive life.

Chapter 7 reviewed and refuted 11 reasons that are invoked by large international companies to justify putting off the start of an HIV treatment programme. In 2010, these arguments in favour of HAART provision retain their validity. The HWPP proves that it is possible to deal with the complicated nature of treatment protocols. The costs of ARV are affordable for a company. Africans have essentially the same capability for adherence as patients on other continents, and a good WPP can provide sufficient attention to encourage this adherence. Many businesses enjoy a long-term presence in Africa, so the sustainability of a WPP is not a major issue. So far, Heineken’s well-run programme has not encountered major issues with drug resistance. The advantages enjoyed by employees can encourage or pressure governments to match these benefits for their own employees. Public health is the responsibility for all: employers should deal with all diseases affecting the health of their workforce community. They should not deny effective treatment for any reasons linked to moral judgments or disapproval if, for example, a disease is transmitted by sexual contact. Finally, the treatment offered by HWPP has reinvigorated all HIV prevention efforts, showing that these two components need not be in competition.

For a large company not to include ARVs in the health care benefits for their employees and spouses is inexcusable. The conclusions of this viewpoint are that treatment of HIV with ARVs should be part of the medical benefits the workers can enjoy.
4. Ongoing operational research

It is hoped that the findings and conclusions presented in the papers in this thesis will inspire and guide other employers in Africa to express more concern for the well-being of their employees. The data applies not only to large and small companies but to governments, which are usually the single biggest employer in any SSA country. However, as mentioned earlier, the papers do not cover all aspects of corporate WPPs but rather concentrate on selected topics of particular interest. Several aspects of the WPP have not been analysed, but additional studies are ongoing that should lead to further improved operational results:

- **HIV incidence**
  Enrolling HIV-1-infected persons in treatment programmes will reduce transmission of HIV-1.\(^{16,17,18}\) Prevention of new cases can be furthered by changing sexual behaviour and also by implementing structural strategies and reducing risk taking.\(^{19}\) The Heineken WPP features important prevention components (Information, Education and Counselling, condoms, assured treatment, personal support and counselling, PMTCT). To demonstrate their impact, decreased HIV incidence would be the indicator, but data has been difficult to obtain. Until recently, people who presented themselves for VCT at the OPCOs received a new personal code every time they appeared which meant that HIV data on a person could not be linked to past data on that same person. A structural change in the set-up of the HWPP database will now make the analysis easier. A subgroup of particular interest is the HIV-serodiscordant couples. Will provision of ARVs to the seropositive partner reduce or even eliminate transmission to the seronegative partner?\(^{20}\) Is there a difference in transmission rate if the male partner is circumcised? However, even when the HIV incidence rate goes down, the economic burden placed on employers will not diminish. Effective treatment will need to be paid for life.

- **PMTCT**
  Since 2002, the recommended protocol for PMTCT in the HWPP is to use tri-therapy for the mother and single-dose nevirapine for the newborn, with possible extension of the tri-therapy duration period in case of breastfeeding.\(^{6}\) Preliminary analysis shows that the implementation of the protocol is often incomplete, but the number of cases is low and does not allow for statistically sound conclusions. The ambition that not one single case of mother-to-child transmission should occur in the beneficiary population has not yet been realised. The determinants of the success or failure of this PMTCT programme in the workplace will need to be examined by qualitative and quantitative research.\(^{21}\)
• **Tuberculosis**

As some national TB programmes did not allow application of IPT, the efficacy of IPT to reduce activation of tuberculosis could not be evaluated. The recent emphasis on WHO's three 'I's programme (intensified case finding, isoniazid prevention therapy, and infection control) and the Stop TB Partnership can potentially make national programmes change their policy.

• **Productivity/cost-benefit analyses**

A question that has not been formally studied is the effect that ART has on labour productivity. ART was shown to reduce AIDS incidence and mortality, but how important was the related reduction of absenteeism? The costs and benefits of the HWPP have also not been determined.

• **Prolonged mortality reduction**

It will be important to monitor whether the ART effect on reduction of mortality can be sustained after the first five years of analysis described in this thesis. After the initial period, the number of contacts between health care provider and the patients might become less intensive, reducing ART-adherence and long-term treatment success. Mortality might increase again over time.

• **Expansion of programme**

The overall programme is a success, but it has a small impact in terms of lives saved, if measured against the existing needs in the society.22 How can a company do more? What kind of actions are possible and feasible to expand WPP benefits to people in a company’s supply chain—the smaller companies that deliver goods and services to the larger company?23 Operational research is under way to determine the possibilities of stimulating supply companies to implement their own WPPs. However, the delivery model of prevention and care and the scope of such extended programmes will differ from the one herein described, since smaller companies have fewer human and financial resources to execute all aspects of the HWPP. Certainly in-house provision of ARV would be a particular challenge.

• **Advocacy**

The Heineken WPP has made and continues to make significant contributions to the advocacy of HIV treatment in Africa. Even though the policy of Heineken is to run the HIV-WPP as an integral part of its standard health packages—and not to gain publicity—its groundbreaking work has received international attention, and advocacy papers and studies are still ongoing.
5. Translation into action for the business community: the SWOT analysis

This thesis is a scientific evaluation of an actual programme, but also a plea for business action. In order to convince businesses, the language understood by businesses has to be used. Summary of the HWPP experience in a format often used by businesses, the Strengths, Weaknesses, Opportunities and Threats (SWOT) analysis may be helpful. Some of the findings that are mentioned in this SWOT analysis are experience-based rather than scientifically validated. In any case, business leaders will make policy based on findings appealing to the business community.

Strengths of Heineken's HIV workplace programme

1. Medical infrastructure. The HWPP is supported by a robust medical infrastructure that has the capacity to implement ART at Heineken OPCOs.

2. Funding. The HWPP has sufficient funds available to support both treatment/care and prevention programmes for HIV/AIDS.

3. Reduced mortality and morbidity. The HWPP effect on patient mortality was immediately visible; the same is true for morbidity. Lower incidence of AIDS means that workers remain productive. Costs of treating HIV-related opportunistic infections decreased.

4. Reduction of stigma. When people start living normal lives again, despite HIV, the subject becomes easier to discuss.

5. Increased morale. Because of success, the medical staff at last finds the energy and courage to focus on prevention programmes. The number of newly diagnosed infections declines amongst long-term employees and the worker's morale increases.

6. Reputation gain. The ‘miracle’ of turning an HIV-infected person into a healthy person increases the confidence of the workers and their spouses in company clinics and brings them in for other health problems. It improves worker respect for the company. It also improves the reputation of the OPCOs as socially responsible enterprises in their respective communities.

7. Information. The fact that the HWPP is being supported by strong and accurate databases has resulted in the production of a wealth of practical and operational data, which are of interest for the international business community and beyond.
8. **Advocacy.** Apart from wide international attention in the press and other media, Heineken was also one of the founding members of the Dutch “PPP group”, a unique consortium involving the Netherlands Ministry of Development Cooperation, the NGO PharmAccess, and the multinationals Unilever, Shell, Celtel (now Zain), and Heineken.

**Weaknesses of the HWPP programme**

1. **Stigma challenges.** Even though HIV stigma seems to decline, no seropositive employees at Heineken had decided to engage in prevention and peer education a programme, showing that fear of stigma continues to exist.

2. **Inequity issues.** The fact that Heineken offers generous medical services including HIV treatment to its employees and dependants contributes to “inequality” in the community. The gap between the employed and unemployed is growing in OPCO areas.

**Opportunities**

1. **Increased prevention efforts.** In the years prior to the ART programmes at Heineken, HIV-prevention activities were undertaken mainly out of a sense of duty, but the commitment was low. The new attention to treating HIV can invigorate prevention programmes.

2. **Scaling up.** The lessons learned from a small programme can be instructive for larger-scale programmes. Companies can learn from each other how to deal with various problems and how they can play a greater role in HIV prevention and the promotion of access to treatment.

3. **Increased Corporate Social Responsibility standing.** The pioneering role of the HWPP creates a lot of goodwill towards Heineken. It has improved its standing as a ‘caring company’. The Corporate Social Responsibility return is very high.

**Threats**

1. **HIV prevalence.** A successful HIV-WPP saves lives. At the same time, a paradox has to be explained to outsiders: the more
successful a WPP, the higher the HIV prevalence within the employee community will be. Persons under treatment will stay alive and productive, and the number of patients will continue to grow as long as the target of prevention activities (zero new infections) is not reached. Zero new infections might be a conceivable goal for employees with sufficient exposure to WPP messages and activities. However, a company is an open system: new employees will be recruited and amongst those there will be seropositives.

2. **Complacency.** The absence of visibly infected persons might have reduced some of the direct concerns about the HIV epidemic. This might have created a false sense of security. The danger is that the need for prevention activities is felt less urgently.

3. **Continuity.** Heineken remains committed to continuation of treatment for everybody who once started treatment unless a qualitatively similar programme is locally available. This is a challenge if the drugs provided by a local public sector programme are inferior to the drugs in the Heineken programmes. As long as no definitive cure exists, ART will have to be paid for life.

4. **Scaling up.** The total population in the Heineken WPP that is enrolled on HAART today is less than 500 persons. This is a substantial number, but considering the size of the global HIV problem, the impact remains small. Can companies contribute more? Will the good performers be pressured to do more and obliged to provide treatment to [their] suppliers?

6. **Next steps and final considerations**

The success of worldwide treatment programmes has kept many people alive. This has benefitted the individuals and their families, the wider community, and related social and economic networks. In 2010, it appears that the financing of HIV treatment is under pressure due to the global economic crisis and the reduced international funding for antiretroviral supplies. Ambitions are clearly dampened. However, the persons on HAART, now facing a chronic disease instead of death sentence, will remain dependent on medication for the rest of their lives. With increasing success in roll-out of ARV programmes, ever more people will need expensive drugs.
At the same time, new infections keep occurring: results of prevention activities are unsatisfactory. People with new infections will eventually need treatment to survive. One has to keep in mind that to date, only one third of African HIV patients who need ART actually have access to these life-saving drugs. Yet the current global financial crisis raises serious concerns with respect to expansion and even sustainability of current ART programs in Africa.

Theoretically, a test-and-treat policy will reduce HIV transmission and new infections, but this policy cannot become reality if commitment and funding are lacking to pursue that goal.

An effective HIV vaccine, another possible solution to limit new infections, is a distant possibility and not realistic in the coming years. Even if some small steps forward seem to have been made, it remains uncertain if a preventative vaccine will ever materialize, mainly due to the changeability of the virus. In addition, the long-term population impact of circumcision still needs to materialize. Thus, in light of limited effects of HIV prevention, the emphasis will remain on AIDS treatment for many years to come.

One of the important cornerstones of the success of WPPs in the Heineken African OPCOs proved to be the collaboration with NGO partners. This collaboration did not follow an 'outsourcing' or 'subcontracting' model but represents a true partnership, with transfer of knowledge and expertise from the experts at PharmAccess to the in-house medical teams of the OPCOs. Another cornerstone was the close involvement of the Heineken Health Affairs department (i.e., the medical policy makers for the Heineken Group), who made the WPP an integrated part of business operations. Other large companies should recognize the importance of in-house medical expertise, and the need for cooperation between medical staff, policy makers, and outside experts like PharmAccess. Not only HIV but also other global health challenges need to be tackled in a concerted way, by using the strengths of a number of partners.

Companies often call their employees their prime asset. When doing business in Africa, paying for HIV treatment is thus a logical step. It should become part of normal business practice. The costs of paying for health care programmes including effective HIV interventions will not make the difference between running a profitable company or not. Indeed, if expansion of global HIV treatment becomes truly endangered, companies could take an even greater share of treatment responsibility, leaving the public sector the responsibility of caring for unemployed or self-employed persons who cannot afford the necessary costs.
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