Letters to the Editor

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HIV and AIDS in Africa

1. Assisting Those in the Early Stages of HIV Infection

In their article on care of human immunodeficiency virus (HIV) disease in Africa, De Cock et al. make the recommendation, primarily on equity grounds, that antiretroviral therapy ought to be made available in Africa.[1] I do not wish to debate the merits of their argument, as others will certainly take up the point, but I would nonetheless stress that this is not the main point of their paper and will probably divert attention from some of the other valid points they have made. Perhaps the most important of these is that in focusing on the problems posed by terminal care of patients with end-stage acquired immunodeficiency syndrome (AIDS), we risk equating HIV disease with AIDS, thereby missing opportunities to make useful and cost-effective interventions at earlier stages. Asymptomatic patients whose HIV status is known and patients with early HIV disease can benefit from treatment of opportunistic infections,[2] advice and counseling,[3] and possibly prophylaxis, especially for tuberculosis.[4] All of these interventions could prolong the useful working life of patients with HIV disease, and most can be delivered on an outpatient basis at district hospitals and health centers.[5] For every AIDS patient in hospital there are probably 10 or 20 patients with HIV disease in the community, struggling to stay well enough to keep their jobs and to conceal their illness and trying to decide what to do about their own and their children's future. Adequate and affordable care for such people can be provided without advanced diagnostics or expensive drugs[6] and ought to be provided as part of the routine health services in heavily affected countries. □

Susan Foster

Requests for reprints should be sent to Susan Foster, Department of Public Health and Policy, London School of Hygiene and Tropical Medicine, Keppel St, London WC1E 7HT, England.

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2. Research Priorities Should Not Be Limited to Prophylaxis

In their article, De Cock et al. stress the importance of improving care for patients with human immunodeficiency virus (HIV) infection in low-income countries.[1] While we agree that this issue has, so far, received too little attention from researchers as well as by the donor community, we have reservations about some of the points made by the authors.

De Cock et al. wrote their paper out of concern about inequalities in the care of patients with HIV infection. They state that differences in access to life-prolonging therapies have never been as large as they are in the case of acquired immunodeficiency syndrome (AIDS). This is clearly an overstatement. For instance, in developing countries 1 in 50 women dies as a consequence of pregnancy and childbirth, compared with only 1 in 2700 in industrialized countries.[2] Second, we feel we have to be careful not to overestimate our therapeutic capacities for HIV-infected patients. We certainly spend a lot of money on the care of patients with HIV infection. But what exactly do we get for that money? The Concorde study has shown that the usefulness of early zidovudine treatment has been overestimated.[3] Now there is a move toward combination antiviral therapy, but where are the data to show that such treatments considerably increase life expectancy and improve quality of life?

The research program proposed by De Cock et al. puts a lot of emphasis on treatment and prophylaxis studies of opportunistic infections. We wonder whether the results of these studies will lead to a major improvement in the care of patients with HIV infection in developing countries. We would like to propose other research priorities. What is urgently needed is to know how care is organized, what the shortcomings are, and how these shortcomings can be overcome in the most cost-effective way with the available knowledge. Above all, we have to make an assessment of the needs of all persons with HIV infection, not only those who are terminally ill, as proposed by the authors.

Fighting against discrimination, trying to improve socioeconomic conditions, and improving general health care services may be what is most needed to improve the quality of life of persons with HIV infection. □

Robert Colebunders, MD
Henk Van Renterghem
Anne Buvé

The authors are with the Institute of Tropical Medicine, Antwerp, Belgium.

Correspondence should be sent to Robert Colebunders, MD, Institute of Tropical Medicine, Nationalestraat, 155, B-2000 Antwerp, Belgium.

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3. *De Cock et al. Respond*

We appreciate the concerns raised by Dr Biggar about the difficult choices faced in providing an effective response to the human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS) epidemic in Africa and the rest of the developing world.[1] Our point was never to suggest that the already limited funds for prevention should be diverted to provide care and treatment for persons with HIV infection. Rather, we argue that care and prevention are linked, that a complete response to the epidemic should also address the issue of care, and that without a rational response to the requirements for care funds risk being spent inappropriately.

Tuberculosis and sexually transmitted diseases, conditions closely associated with HIV infection in Africa, are examples of diseases that require treatment for their control and prevention. Both have been greatly neglected by international donors, perhaps in part because of aversion on the part of such agencies to financing the procurement of drugs. The developing world already spends about $340 million annually on the care of patients with HIV disease.[2] No matter what experts like Dr Biggar say, AIDS patients will continue to present to the health care system and ministries of health in developing countries will continue to grapple with the issue of how best to care for them. It is imperative that funds for AIDS care be spent in as effective a way as possible, and this is unlikely to happen without the kind of research that we outlined.

We agree with Drs Biggar, Foster, and Colebunders et al. that the use of antiretroviral drugs in Africa is inappropriate at the present time, especially because of their limited efficacy and great cost, and our article did not argue for their widespread use. Our purpose in discussing antiviral drugs was to highlight the needs of patients in resource-poor areas; the development of affordable and effective antiviral drugs should be a priority. The Global Programme on AIDS has already considered the possibility of studies incorporating zidovudine and other agents for the reduction of perinatal transmission of HIV. If truly effective therapies for AIDS were developed—as are available for tuberculosis, for example—it would simply be unacceptable to limit their use to industrialized countries for reasons of price, any more than an effective AIDS vaccine could remain out of range for Africa.

Dr Colebunders and colleagues make many valid points with which we agree. Certainly, maternal mortality is a hidden and neglected epidemic; equally, much more needs to be done in making optimal use of what is already available and in fighting discrimination. However, patients require care and treatment, and we need to define what is a minimum acceptable standard of care for HIV disease in a resource-poor environment.

Dr Biggar's caution about preventive therapy for tuberculosis is well taken, but it cannot be used as a justification to do nothing. Overall, the tone of Dr Biggar's editorial is one of acceptance of the status quo. We share the views of the references he quotes[2,3] that change is needed, above all an increase in funding for AIDS prevention and control. □

Kevin M. De Cock, MD, MRCP, DTM&H
Sebastian B. Lucas, FRCP, FRCPath
Sue Lucas, MSc
Justine Agness, MD
Auguste Kadio, MD
Helene D. Gayle, MD, MPH

Requests for reprints should be sent to Kevin M. De Cock, MD, MRCP, DTM&H, Department of Clinical Sciences, London School of Hygiene and Tropical Medicine, Keppel St, London WC1E 7HT, England.

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Increasing the Effectiveness of HIV Counseling

Otten et al.[1] raise serious concerns about the impact of human immunodeficiency virus (HIV) counseling and testing among sexually transmitted disease clients. Lack of behavioral change subsequent to HIV counseling and testing (or increased risk behavior among seronegatives) warrants reassessment of HIV counseling and testing procedures. The apparent ineffectiveness of counseling, however, may be peculiar to this clinic's stated procedures.

The clinic's protocol was geared toward high-volume HIV testing among their sexually transmitted disease clients, 45% of whom were tested during the study period. Such a protocol does not allow for comprehensive, effective pre- and posttest counseling. A 5-minute pretest counseling session was used to (1) assess knowledge of HIV, (2) assess and discuss risk for HIV infection, (3) provide risk reduction education, and (4) offer testing. Five minutes is too short a time to accomplish all these objectives, and full information cannot be effectively conveyed or integrated. Severely abbreviated messages may serve to confuse the client. The data from Otten et al.'s study suggest that a negative HIV test may unintentionally serve to validate an individual's prior risk behaviors.