

# HATiP

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## In this issue:

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### **Experts at 2009 HIV Implementers' meeting worry about sustainability of HIV programmes; *by Theo Smart* **page 2****

- An expanding epidemic and a shrinking pot of money?
- Funding for HIV versus general health systems strengthening
- A change in leadership and political will
- Getting countries to pull their weight, and partners to harmonise efforts
- What can be done
- The role of activists and people living with HIV

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### **Making the money work harder: the new reality of HIV scale-up; *by Carole Leach-Lemens* **page 7****

- Potential effects of the economic crisis on AIDS programming
- Where are we now?
- Opportunity in crisis
- How to reduce the risk of programme interruptions in the event of a funding shortfall

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### **Dr Kevin De Cock calls for end to suboptimal HIV care for resource-limited settings; *by Theo Smart* **page 9****

- Epidemiology
- Prevention
- Treatment guidelines
- The future of universal access and the arc of history

## Experts at 2009 HIV Implementers' meeting worry about sustainability of HIV programmes

By Theo Smart

"In the last several years, we've seen global funding for HIV/AIDS dramatically increase," said Elizabeth Lule, Manager of the World Bank's HIV/AIDS work in Africa, at a press conference before the start of this year's HIV Implementers' Meeting in Windhoek, Namibia.

But now, Lule said, "the environment has changed."

Indeed, the overarching issue of the HIV Implementers' Meeting was how to sustain the recent gains made in the fight against HIV/AIDS in resource-limited settings in a changing environment.

"The meeting is happening at a critical juncture of our fight against HIV and AIDS," said Professor Rifat Atun of the Global Fund during the meeting's opening plenary. "Rather paradoxically, on one hand, we should be celebrating real success [of the scale-up of HIV/AIDS programmes] that are having visible impact, but we are at a juncture where globally we are experiencing the most difficult economic conditions since the Great Depression... and where the influence of the adverse condition on the countries is not yet known. We're not sure what the impact might be."

Other experts at the meeting worried about other important shifts in the environment: namely there has been a decrease in donor interest in funding HIV/AIDS and an increasing preference for support of general health systems strengthening; and that changes in political leadership — in the US and elsewhere — are translating into a loss of the political will to continue treating HIV/AIDS as an emergency.

Meanwhile, the increasing numbers of people with HIV progressing to AIDS, and the ongoing failure to curb the incidence of new HIV infections mean that the numbers of people needing care will continue to grow and grow — making HIV programmes in resource-limited settings even more difficult to sustain.

Consequently, the official theme of this year's HIV Implementers meeting, 'optimising the response, partnerships for sustainability,' became something of a warning for those working in countries that they should batten down the hatches, make sure to get the most out of what they have, and do whatever else they can to keep their existing programmes afloat in an era of dwindling resources and waning global interest.

### Was the expansion of AIDS care and treatment during the last decade merely a brief anomaly?

In the past decade, billions of dollars have been disbursed to perform a health care miracle that many said would be impossible in resource-constrained settings only a decade ago — the national scale-up of projects to prevent mother to child transmission (PMTCT) of HIV and the launch of HIV treatment and care programmes reaching millions of adults and children, including the rollout of antiretroviral therapy to 3.4 million people. The demonstration that a public health approach to HIV treatment could indeed be implemented in resource-constrained settings led UNAIDS and

activists to designate universal access to HIV treatment by 2010 as the new goal for advocacy.

Each year, the HIV Implementers' Meeting serves as a forum for those working in the trenches to share the lessons they have learned about what does and doesn't work delivering HIV prevention, treatment and care. It also provides funders and sponsors (who this year included the US President's Emergency Plan for AIDS Relief (PEPFAR); the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund); UNAIDS; UNICEF; the World Bank; the World Health Organization; and the Global Network of People Living with HIV (GNP+) an opportunity to showcase their initiatives and the progress that has been made.

For instance, there were several presentations from representatives of the meeting's founding co-sponsor, PEPFAR, which was launched in 2003 as a five-year commitment and quickly became the largest public health initiative ever dedicated to a single disease. To date, the US government has contributed ~ \$25 billion to the global fight against HIV/AIDS through PEPFAR, and is also the largest supporter of the Global Fund.

While some of PEPFAR's prevention work has been rather controversial (with ring fencing of funding for faith-based abstinence and being faithful projects, and the 'anti-prostitution loyalty oath' for instance), it has had great success catalysing HIV treatment and care programmes in the original 15 'focus' countries.

Consequently, in 2008 PEPFAR was reauthorised for an additional five years to the tune of \$48 billion. It is important to note however, that reauthorisation does not guarantee that the Obama administration or Congress intends to follow through with funding commitments (see below).

But under PEPFAR II, the plan at least is for the US government to support: treatment for 3 million people, prevention of 12 million new infections, care and support for 12 million people (including 5 million orphans and vulnerable children), in partnership with host countries around the world. To meet these goals, PEPFAR has also committed to support the training of at least 140,000 healthcare workers in HIV/AIDS prevention, treatment and care, including new cadres of healthcare workers.

The question is now, whether the current administration will continue the 'emergency' response.

### An expanding epidemic and a shrinking pot of money?

Over the last year, the leadership in the US, and many other industrialised countries have become preoccupied with the global economic crisis. The crisis makes it look less and less likely that the industrialised world and multilateral funding partners will sustain current levels of aid for health in the resource-constrained settings, not to mention to meet their commitments to support universal HIV treatment access by 2010.

"This is the biggest single issue facing the global AIDS movement at the moment," said Dr Fareed Abdullah, director of the Global Fund's Africa unit. "Our level of coverage for antiretroviral therapy is presently quite low and by all accounts we don't have enough money on the table, between PEPFAR, the Global Fund and national governments to put the people who need it on treatment."

Indeed, in Africa alone, there are 3.9 million people living with HIV in immediate need of treatment under current guidelines. Because of recent data showing dramatic reductions in mortality when treating people with CD4 cell counts below 350 (rather than waiting for their CD4 cell counts to fall below 200), there are moves afoot to bring the eligibility requirements for ART closer to the norm

in industrialised countries (starting treatment when the CD4 count falls to 350 rather than 200). This could indeed save lives and may also result in a reduction in onward HIV transmission, but it would also increase the numbers qualifying for treatment dramatically.

It should be noted however that most people with HIV are not being identified or coming in for treatment until their CD4 cell counts are already very low so it is not clear what the impact of changing eligibility requirements would actually be — earlier treatment may, in fact, lead to a reduction in utilisation of other health services, such as hospital beds, diagnostics and treatment of opportunistic infections.

Even if eligibility requirements for ART aren't changed, the numbers needing treatment will continue to increase each year.

"Because of the numbers of new patients who are moving from HIV to AIDS, our level of coverage next year may be even lower than it is now," said Dr Abdullah.

On top of this, there is the unrelenting tide of new infections.

"There are about 33 million people with HIV globally, but about 4 million people are added to the ranks each year," said Helen Jackson of UNAIDS. "In countries like South Africa, where over 400,000 people each year are infected, this has clear implications for the sustainability of the HIV programme."

"We cannot beat this epidemic with treatment alone," said Dr Tom Walsh, Acting Deputy US Global AIDS Coordinator during the opening plenary. "In some areas, there are five new infections for every two people who are newly added on treatment. Without effective prevention for those not yet infected, more and more will face the risk of death — and be in need of treatment. And without successful prevention and treatment, the number of children orphaned by AIDS will continue to grow."

And yet, by most accounts, prevention programmes are most likely to suffer in the economic downturn.

"Prevention efforts are at most risk, more than ever, because countries will emphasise investments in treatment, to reduce the mortality," said Lule. "A recent World Bank and UNAIDS survey of 71 countries showed that nearly half of those nations — representing at least 75% of people with HIV/AIDS — expect prevention programs for people most at risk to be affected by the economic crisis. And this is extremely worrying because less prevention and more new infections will mean higher future treatment needs with larger future cost implications."

Without a renewed commitment to funding for HIV/AIDS, it will be impossible to keep up with the demands for treatment. Worse, it may not even be possible to sustain existing programmes.

"If the funding flow to fight HIV/AIDS were to be constrained, much of the achievements to date and all the efforts we have made so far could potentially be undermined," said Prof. Atun.

"The Global Fund estimates that our own funding gap is about \$4 billion, not all of that is for ART but a significant proportion is," said Dr Abdullah. "We need to join hands to ask from a world where cash is short for more money for treatment. That's a big ask right now but ...it's not an option to tell people there is no money for their treatment."

"In some countries we've already seen in the newspapers that moratoriums have been put on new people for treatment," said Lule.

The host country of this year's conference, Namibia, stands out for reporting great progress on providing treatment and care to its people with 80% of those qualifying for ART on treatment. However, they are 60% dependent upon donor funds.

"What happens if the donors don't come up with that money?" said Lule. "What is plan B for many of these countries?"

In many settings, if something isn't done soon, according to Dr Abdullah, "we will start to see more and more drug shortages because of the funding gap."

"So much is at stake," said Lule. "A resurgence of mortality and morbidity; unplanned interruptions and curtailed access to treatment will increase HIV transmission rates because the viral loads will go up; future treatment failure and drug resistance is completely unaffordable. And of course, this means higher future fiscal costs or increased burden on health systems. We don't want to go back to the earlier 1990s when many of the hospitals in Eastern and Southern Africa were just overcrowded with people dying from AIDS. We can't afford to go back."

## Funding for HIV versus general health systems strengthening

[At the same time, another issue is affecting how some donors are now approaching support of global health. Over the last few years, international agencies and academics have been embroiled in an ongoing debate about the wisdom of disease-specific aid \(e.g. for HIV/AIDS\) versus funding for general health systems strengthening.](#)

Last week an extensive review of the evidence on the effects of global health initiatives published in *The Lancet* (the WHO-led Maximising Synergies project) concluded that global health initiatives have had both positive and negative effects on health systems. The authors, a group of more than 60 academics, programme chiefs and global policy makers, made five recommendations, based on their analysis of over one hundred studies:

- Infuse the health systems strengthening agenda with sense of ambition, the scale, the speed and the increased resources that have characterized the GHIs
- Agree on clear targets and indicators for health systems strengthening;
- Promote country capacity for strong national planning processes and better alignment of resources with national planning processes;
- Promote the meaningful involvement of civil society organizations in the governance of health systems and the delivery of health services;
- Improve evidence-based decision making in health by building the capacity of countries to generate and use knowledge.

These nuanced and careful conclusions are likely to be used by both sides of the debate to justify their positions. Unfortunately the Maximising Synergies report does not provide much HIV-specific information.

However an independent review by the Global HIV/AIDS Initiatives Network, a global network of health systems researchers based at London School of Hygiene and Tropical Medicine, published this month in the journal [Health Policy and Planning](#), provides some useful analysis. They note that while PEPFAR, the Global Fund and the World Bank Multi-country AIDS Program have been successful in supporting scale-up, in channelling funds to the non-governmental sector and in getting more stakeholders involved, they have also distorted national health systems priorities in some settings and created vertical systems.

But the researchers also point out that global HIV/AIDS initiatives should not be dismissed, and make some constructive recommendations about how to address current problems:

- Global HIV/AIDS initiatives could do more to align with national health priorities, and should coordinate investment to strengthen national health systems;
- Global initiatives should give countries sufficient flexibility to address health system weaknesses and strengthen implementation, especially in human resources;
- Better coordination of donor investment to meet national health priorities, with flexibility to allow global initiatives to support the areas they can fund, allowing other resources to flow elsewhere;
- Global HIV/AIDS initiatives must provide long-term funding to address the shortage of public health sector staff;
- Global HIV/AIDS initiatives must continue to fund the non-governmental sector, but should require NGOs to utilise and contribute data to national health information systems, to ensure a joined-up approach.

It should be a false dichotomy — health systems strengthening is essential for the optimal success of HIV/AIDS programmes, and HIV/AIDS support should and could be designed and delivered in a responsible way that strengthens health systems. Occasionally, it was necessary to pilot a service vertically to demonstrate it was possible in a setting, but the goal has long been to mainstream HIV/AIDS services into the public health system as soon as possible. Indeed, WHO launched the 3 x 5 initiative in 2003 specifically to promote the delivery of antiretroviral treatment through the public health system through standardised protocols that would eventually allow delivery through primary care.

Services have been shown to be most effective when delivered locally — as close to where the patient lives as possible — through the primary health clinic, community-based and home-based care. This has been the public health approach that HATIP has been describing for the last five years, and universal access is impossible without a generalised scale-up of the capacity of primary care.

“You can reach a certain level of coverage without addressing the health system’s weaknesses, but when you go to scale up, as we all want to with universal access, then the health systems become particularly critical,” said Dr Abdullah.

The critics of HIV/AIDS funding frequently point to dated examples of the early HIV/AIDS response as a separate vertical system — suggesting that this will go on indefinitely and that “far too much is spent on HIV relative to other needs and this is damaging health systems.” But the critics forget that AIDS services are also rescuing health systems that were (and would be) inundated with people ill or dying of AIDS and TB. And they ignore the dynamic nature of the HIV/AIDS response and that HIV implementers have demonstrated capacity to adapt their practices and integrate services to make them more effective.

But the accusation that HIV/AIDS is getting too large a share of international aid for health seems to have taken hold and in an important sense, has helped the critics of HIV/AIDS funding win the rhetorical debate.

One indicator of the shift is how funding is being redirected from HIV/AIDS to general health systems strengthening. According to sources at WHO, the HIV Department has suffered a dramatic reduction in funding, with donors such as the Scandinavian countries now redirecting their funds to general health systems strengthening. But there is a real danger that, in the current economic climate, the debate will simply provide a convenient excuse for industrialised countries not to honour their commitments to supporting universal access.

PEPFAR insiders have told HATIP off the record that they are extremely worried that the debate is beginning to diffuse PEPFAR's focus on HIV/AIDS.

HIV/AIDS funding critics have adopted one particularly insidious tactic by pitting the needs of ‘innocent children’ against people living with HIV, arguing that infant mortality is receiving insufficient attention due to the emphasis on AIDS, and that many lives could be saved with inexpensive measures to prevent or treat diarrhoea and pneumonia.

Ezekiel Emanuel, brother of White House chief of staff Rahm Emanuel, while accepting that the US must continue to meet its responsibilities to people already on treatment, explicitly criticised further increases in PEPFAR spending on HIV/AIDS in [a recent commentary](#) in the *Journal of the American Medical Association*, arguing that “doubling or tripling PEPFAR's funding is not the best use of international health funding ... By focusing so heavily on HIV/AIDS treatments, the United States misses huge opportunities. By extending funds to simple but more deadly diseases, such as respiratory and diarrheal illnesses, the U.S. government could save more lives - especially young lives - at substantially lower cost.”

“They have more DALYS,” a PEPFAR insider told HATIP, referring to Disability Adjusted Life Years or the sum of years of potential life lost due to premature mortality and the years of productive life lost due to disability — meaning many more years of life could be saved with MCH interventions than by the relatively expensive HIV/AIDS interventions.

“But they forget that HIV/AIDS is striking adults at the prime of their lives. These are the workers, the family providers. HIV/AIDS threatens the security of families and the economic system —and it disproportionately affects teachers and healthcare workers upon which the educational system and health system relies.”

Low-cost interventions to save the lives of children from easily treatable and preventable illnesses should of course be made more widely available.

However, it is important to point out that maternal-child health is a perennial issue for which host governments must be held directly responsible. The health systems in these countries have indeed been weakened, but the main culprits for this were the disinvestment in health systems dictated by the structural adjustment policies of international financial institutions (such as the IMF) in the 1970s, 80s and 90s, and the subsequent failure of developing countries to allocate sufficient resources to health.

Debt forgiveness and policies that enable developing countries to invest in their own health systems may be the best way to strengthen general health systems in a way that is ‘home-grown’ and sustainable.

But it is another issue entirely whether funding should be directed away from the HIV/AIDS pandemic, which is indeed an unprecedented emergency that many high-burden countries are poorly equipped to manage and which does in fact require an exceptional response.

But has the debate affected US government policy?

“A big priority for the Obama administration is to continue our support for HIV/AIDS but to look at it in a broader context of public health issues around the world. So he recently launched something called the global health initiative, committing to spend \$63 billion over the next 6 years (70% of which is for HIV/AIDS, TB and malaria),” said Michelle Moloney-Kitts, Assistant Global AIDS Coordinator for the US government at the opening press conference. “He is hoping that we can use the platforms PEPFAR has developed to look at other issues that affect families such as diarrhoeal diseases in children, maternal mortality, neglected tropical



diseases, and that this comprehensive approach will in fact be more responsive to what people really need in the field and in the country and that will also contribute to the long-term sustainability of our programmes.”

### A change in leadership and political will

At first glance, the global health initiative seems like a balanced approach. The problem really is in the maths: 70% of \$63 billion is only \$44 billion — and that’s over 6 years. PEPFAR reauthorisation was for \$48 billion over 5 years. Simply put, it amounts to a cut.

“The only aspect of the plan that appears “new” is a dramatic decrease in funding for programs to address HIV, malaria and tuberculosis,” according to a Health Global Access Project [press release](#).

“President Obama repeatedly committed to ensuring the US does its fair share to fight AIDS around the world. But this budget’s drastic cuts to funding for AIDS, TB and malaria shows that his promises were just rhetoric,” said Kaytee Riek, Director of Organizing for Health GAP.

An [Irin PlusNews](#) report concluded that the Obama administration was expanding the global health agenda, but not funding, and pointed out that this was pretty much in tune with the perceptions of the American public. A recent Kaiser Family Foundation survey reported that ‘71 percent of Americans do not believe their country can afford to spend more on global health when the US is experiencing a severe recession, and that the sense of urgency about the global HIV/AIDS epidemic had declined.’

Others think it is an indication that HIV/AIDS isn’t high on Obama’s agenda — with another sign being the long delay in appointing and getting Dr Eric Goosby confirmed as the next US Global AIDS Coordinator. In fact, in a feat of bad timing, Dr Goosby’s confirmation hearings in Washington started at the same time as the HIV Implementers’ Meeting.

“Regardless of what you thought of their politics, both President Bush and his wife were deeply engaged in PEPFAR,” one PEPFAR insider told HATIP. “That not only gave us a clear mandate, it protected PEPFAR from the predations of other agencies and competing interests in the government. We don’t have that protection anymore.”

Indeed, according to one PEPFAR official: “We tried really really hard to get Obama to record a greeting for the meeting. Either Hillary really wanted to do it, or he didn’t.”

### Getting countries to pull their weight, and partners to harmonise efforts

Still, as the exiting Director of the HIV/AIDS Department of WHO said in his opening plenary address “We cannot expect one country to carry the world’s HIV treatment costs.”

Already, with the reauthorisation of PEPFAR, there is a drive to get countries to pull more of their own weight in the programme.

According to Moloney-Kitts, under PEPFAR II “there is a new emphasis on establishing partnership frameworks — a 5-year joint strategic framework for cooperation between the US, the partner government and other partners to promote long term sustainability of programmes, that strengthens country capacity, ownership and leadership of the HIV programmes, and harmonise efforts with other funding partners. Partnership frameworks are supposed to be transparent (and are to be posted online on the PEPFAR site), and to involve the active participation of civil society, the private sector, other bi- and multilateral partners, and international technical support organizations.

“We look to host country governments and our partners to also be more accountable for their contributions,” said Moloney-Kitts. “In many places key policies need to be put in place to advance and provide long-term sustainability to the achievement of our goals. A concrete example involves mother to child transmission — we know that we will never have a sustainable programme without opt-out and rapid testing. Governments need to commit to a policy on that. PEPFAR provides funding for equipment and lab tests, and the community based organisations commit to organising traditional birth attendants or a community surveillance support system for mothers. Then we can all work in a partnership where we are mutually accountable for what we are trying to achieve.”

Through the partnership frameworks, PEPFAR II means to expand well beyond the first 15 original focus countries. In fact, the US government has invited a long list of countries to develop partnership frameworks including: countries from the Caribbean region, the Central America region, the Central Asia region, Botswana, Côte d’Ivoire, the DRC, the Dominican Republic, Ghana, Guyana, Haiti, India, Indonesia, Kenya, Lesotho, Malawi, Mozambique, Namibia, Nigeria, Rwanda, South Africa, Swaziland, Tanzania, Thailand, Uganda, Ukraine, Vietnam and Zambia.

Malawi — notably, not one of the original focus countries, but a country which has set itself apart as a model for accomplishing a lot on a shoestring with a simple public health approach to HIV care — was the first to complete a partnership framework, which is already available online. Consequently, the US has committed itself to double the HIV/AIDS funding for the country to around \$45 million. Swaziland has also recently completed a partnership framework.

And perhaps in an effort to encourage countries and partners to dedicate more resources to HIV/AIDS, Dr Tom Walsh, Acting Deputy US Global AIDS Coordinator, spoke about how closely HIV/AIDS is linked to other development needs. “One lens through which to look at the impact of HIV/AIDS and our efforts to combat it is that of the Millennium Development Goals (MDGs),” he said.

However, asking resource-constrained countries to contribute more funding to the fight against AIDS during an economic downturn may be another example of poor timing because the financial crisis will reduce the ability of countries to contribute more to their own healthcare systems or make up for any funding shortfall.

“The consequences of the economic crisis are perhaps to be most felt by those who already had the least and suffered the most from both poverty and disease,” said Lule.

“We are going to see a slow down in human development gains unless we maintain the investments. We are beginning to see a slowing down of GNP growth — definitely in southern Africa. We are beginning to see declining private capital flows and reductions in remittances, which actually provide a big income for many of the countries. Tourism is going down in some of the countries. We see weak commodity prices — the demand is going down; and the export markets are also declining.”

### The synergies between the fight against HIV/AIDS and reaching the MDGs

**“One lens through which to look at the impact of HIV/AIDS and our efforts to combat it is that of the Millennium Development Goals (MDGs),” said Dr Tom Walsh, Acting Deputy US Global AIDS Coordinator.**

Many resource-limited countries and funding partners have eagerly taken up the challenge of reaching the Millennium Development Goals — eight international development goals that United Nations member states and at least 23 international organisations have agreed to achieve by the year 2015.

Addressing HIV/AIDS and other priority diseases is one of these MDGs, but Dr Walsh used most of his plenary talk at the 2009 HIV Implementers' Meeting in Windhoek Namibia to discuss how closely HIV/AIDS is linked to development — perhaps to encourage countries and partners to re-prioritise HIV/AIDS as part of their strategy towards fulfilling several of the other MDGs.

**Promoting gender equity and empowering women.**  
“HIV disproportionately affects those who have less power and lower status, helping to explain why women and girls account for nearly 60% of the new infections,” said Walsh. Targeted HIV programmes are needed that focus on gender equity, address male norms and behaviours, reduce violence and coercion, increase women and girls access to income and productive resources, and increase women's status and legal protection. Effective responses to HIV/AIDS are thus responses that empower women and girls.

**Universal primary education:**  
HIV/AIDS increases the number of orphans, who are less likely to receive schooling than other children — especially girls, who at all ages are pulled from school to assume the role of caregiver after the death of a mother. Meanwhile, large numbers of teachers are dying of HIV/AIDS in some countries. Strong programmes directed at orphans and vulnerable children should reduce the risk that they will be denied education. Prevention, treatment and care programmes are also needed targeting teachers and other education professionals.

**Reducing child mortality:**  
Children now constitute 14% (370,000 of 2.7 million) new global HIV infections and 14% (270,000) of HIV/AIDS-related deaths annually. A Ugandan study has found that the expansion of HIV services led to a decrease of 81% in non-HIV infant mortality, in part because of the reduction of AIDS orphans.

At the same time, there is also a growing recognition that effective prevention of mother to child transmission (PMTCT) and early identification and treatment of HIV infected children can only be delivered by strengthening mother child health (MCH) services so that all the essential interventions to reduce child mortality can be delivered. It makes no sense to get a child onto antiretroviral therapy and then be unable to the child

and its mother effective prevention or treatment for pneumonia or diarrhoea. The Obama administration's global health initiative clearly seeks to address this issue by strengthening MCH services.

**Improving maternal health:**  
HIV/AIDS disproportionately infects and kills pregnant women. Women with HIV are four to five times more likely to die in childbirth but only 18% of pregnant women in sub-Saharan Africa receive HIV testing during their pregnancies, and less than 40% receive antiretrovirals for PMTCT. Effective responses to HIV/AIDS should positively affect maternal health — and HIV screening in PMTCT programmes can help women identify their own needs for treatment — providing a gateway for care and treatment.

**Combating HIV/AIDS, malaria and other disease:**  
There was a greater focus on TB than any other previous Implementers' Meeting, with the growing realisation that it is the most important cause of morbidity and death in people with HIV in sub-Saharan Africa. In many countries, the majority of TB cases occur in people with HIV — and it is clear that “HIV/AIDS is fueling a resurgence of TB including untreatable extensively drug-resistant TB (XDR-TB). As for malaria, two thirds of the cost of delivering insecticide treated bednets is the distribution system. Effective responses to HIV/AIDS must tackle TB... and should improve the platform [strengthen the health system] used by programmes focused on malaria and other tropical diseases,” said Walsh.

Dr Walsh stressed that HIV/AIDS programmes should expand and strengthen health systems overall — in reality, this is not something that can be guaranteed and certainly shouldn't be taken for granted. However, over the course of the meeting, funding partners and programme directors demonstrated that they are putting a great deal more thought into how HIV/AIDS programmes could contribute to general health system strengthening “using the health systems we've built to deliver other high-impact, low-cost care,” as Secretary of State Hillary Clinton said in her videotaped address.

## What can be done

The thrust is that programmes will have to learn to make the most of every cent they have.

“Only programmes that actually achieve prevention, treatment and care are worth the investment. In a global environment of limited resources, the next five years must be a time of achieving increased effectiveness and also efficiency. We must all ensure that we are spending our dollars wisely and utilising our human potential responsibly,” said Dr Walsh.

“Optimising the HIV/AIDS response and achieving sustainability will require an increased emphasis on more efficient use of available resources,” said Lule. “Because for the time being, we do have some money but it has to be used efficiently and effectively,

we have to have better governance and also perhaps less – shall I mention the word? – corruption, in the system.”

The following day, an opening plenary by Dr Stefano Bertozzi, and a skills building session addressed strategies for increasing programme efficiency and effectiveness. These talks, as well as a tool developed by the World Bank to help countries prepare for the impact of the funding crisis – including how to identify funding gaps that could lead to supply interruptions – are addressed in a related article.

But Lule added that more funding must be made available, for the short term to help address urgent funding gaps in providing bridge financing to avoid cash flow and supply interruptions, and for the longer term.

“Sustaining the pledges that have been made for the Global Fund will of course be very critical. But it is also critical for the US Government to continue to increase what they are spending because the demands will keep going up,” she said.

“We know that optimising efficiencies can only go so far,” one PEPFAR official told HATIP. “We need to find more money in order to save the lives of the millions not yet on treatment.”

But he acknowledged that he didn’t know how this would be done in the current economic and political climate.

### The role of activists and people living with HIV

“In our role as AIDS advocates, we must actively resist the notion that vital human investments must inevitably go down when economic growth declines,” said Paul DeLay, newly appointed deputy executive director of UNAIDS, during the opening plenary.

But something that politicians, healthcare policy specialists and implementers sometimes forget is that the HIV/AIDS movement comes with a constituency of millions – people living with HIV and their families.

People with HIV have mobilised before, and could well mobilise again to demand continued and equitable access to treatment.

This writer is reminded of a course that he took while in university on political revolutions. The professor told the class that the most successful revolutions do not occur while people are thoroughly and totally subjugated, but after they have had a little freedom, after they have been given a glimmer of hope, which is then snatched away. That is when people rise up to demand their rights.

The last decade has given hope and new life to millions of people, millions of people who have become treatment literate, who have beaten the odds, beaten stigma and become empowered. It would be best not to stand in their way.

“The demands for resources to fight HIV and TB in Africa are not arbitrary or exaggerated. The availability of resources for HIV/TB is the key determinant of whether or not the right to life for millions of Africans will be realised,” the Treatment Action Campaign and the AIDS Rights Alliance for Southern Africa declared in a press alert for a protest at the start of the World Economic Forum (WEF) in Cape Town held concurrently with the Implementer’s meeting in June.

“Millions of people who are living today only because billions of dollars were invested in ART to keep them alive. We refuse to have this progress undone. As world leaders gather in Cape Town to discuss the economic crisis and to “develop a new roadmap for Africa’s future”, activists around the region will be watching the outcomes of this meeting for evidence of political commitment to the rights of people living with HIV and TB on the continent, and will mobilize to ensure that these rights are protected.”

## Making the money work harder: the new reality of HIV scale-up

By Carole Leach-Lemens

### Potential effects of the economic crisis on AIDS programming

The ongoing economic crisis will demand greater attention to programme efficiency and effectiveness to justify current levels of funding, but should not be used as an excuse to ignore the needs of the developing world or condemn it to second-rate treatment, the HIV Implementers’ meeting heard earlier this month.

“It could get ugly but we can do more with what we have,” Dr Stefano Bertozzi, chair of the UNAIDS Reference Group on Economics told the HIV Implementers’ Meeting earlier this month, referring to the current global financial crisis and its implications for HIV/AIDS funding and programmes.

Getting more money for AIDS has been the focus of global efforts up until now, with less attention paid to getting less AIDS for the money. In 1987 less than \$1 million was being spent on the pandemic. The involvement of the World Bank and subsequently PEPFAR and the Global Fund represented an extraordinary response: by 2008 a total of \$13 billion had been invested in treatment, prevention and care.

Two strategies present themselves in the face of the current situation in which the probability of funding decreases is highly likely, said Bertozzi: 1) continue on the same path and seek to maintain increases in funding levels and 2) take advantage of the opportunity the crisis presents to improve efficiency.

Calls for more efficient use of available resources, coordination and harmonisation and ‘knowing your epidemic’ echoed throughout the conference.

“We need to improve the efficiency of our programmes. Yes, we need new and better drugs, diagnostics and tools, but we can do a much better job with the ones available,” said the Namibian Minister of Health and Social Services, Dr. Richard Nchabi Kamwi, MP, speaking at the closing ceremony. “It is imperative that we make wise investments of the scarce resources put at our disposal, including and starting from domestic resources. Evidence-driven and cost-effective interventions should be the top priority of our plans and programmes. ‘Knowing your epidemic’ - there is no way we can make wise investments if we do not know our epidemic.”

WHO HIV head Dr Kevin De Cock noted that “despite emphasis on ‘knowing your epidemic’ it remains difficult to answer the simple, essential questions – of the last 1000 infections, in whom did they occur, how were they acquired, where and from whom?”

### Where are we now?

Despite 25 years of prevention, Dr. Bertozzi noted that while HIV is arguably an easily preventable disease there were 2.7 million new infections in 2007 with close to 4 million on treatment. Twice as many are dying as are starting new treatment and twice as many may become infected as those who start on treatment. The treatment gap is not even close to a break even point, he said.



AIDS funding to date has seen dramatic increases bilaterally, multilaterally and domestically. The biggest increase, of 616% from 1987 to 2008, from bilateral donors such as the UK, Netherlands, Germany and the Scandinavian countries, is the most vulnerable. Prior financial crises have prompted dramatic decreases in international development assistance (IDA). For example, 10% and 44 % decreases in IDA were experienced with the Nordic and Japanese banking crises, in the early 2000s and the early 1990s respectively.

The World Bank in collaboration with UNAIDS and WHO did an informal survey of staff working in 71 countries and asked about the current and future impact of the crisis on HIV prevention, treatment and care. Close to 50 % of respondents, representing countries with 75 percent of people with HIV worldwide, expect prevention programmes for people most at risk to be affected by the crisis.

Treatment for most of those already on ARVs appears secure for the time being, yet eleven percent noted that the crisis was already having an adverse impact on treatment programmes. Staff responding in 22 countries, where 61 % of those on treatment live, expect an impact on treatment this year. Concern was expressed that planned treatment scale-up for the two-thirds currently in need would not occur. Respondents also reported concern due to budget cuts, uncertainty about future funding, job losses and decreased household incomes as well as increased cost of antiretroviral drugs due to weakened local currencies.

The economic crisis will mean that countries largely dependent on commodities for revenue will be particularly vulnerable to fluctuations in aid. Botswana has seen diamond exports which represent 40 % of the Gross Domestic Product (GDP) drop by 89 %. In Zambia copper prices have fallen by 60%. These outcomes together with cuts in external aid will disproportionately affect the most vulnerable. It is highly probable that short-term staff positions (for example, adherence counsellors) will be cut directly affecting quality of services. Services to most at risk populations (MARPs) will most likely be eliminated. Such cuts would generate little or no political backlash, Dr. Bertozzi suggested.

#### **Worst case scenarios as a result of programme interruption**

- Increased morbidity and mortality
- Increased transmission risks
- Increased treatment interruption leading to
- Increased ART resistance leading to
- Increased burden on health systems and a reversal of economic and social gains

#### **Opportunity in crisis**

Dr. Bertozzi suggested that in times of relative financial stability it is easy to be sloppy and readily see improvements even when they are nowhere near meeting desired outcomes. When there is less money strategic decision-making is a necessity. Interventions will focus on providing the maximum benefit not only in terms of service delivery but in their integration with other services (for example, family planning and TB), as well as ensuring a continuum of care, for example linking VCT to treatment and care.

Dr. Bertozzi, referring to a cost-effectiveness analysis of Information, Education and Communication (IEC) tools undertaken by himself and colleagues for UNAIDS in 2006, noted that there were no cost-effectiveness data for condoms and social marketing.

Implementation of large-scale interventions without measuring their effectiveness was not acceptable. He requested that in the rollout of interventions to reduce concurrent multiple partnerships prospective, rigorous evaluations be initiated so that changes can be measured from the outset. Or, as Dr. Kevin De Cock of WHO put it in his plenary talk, "more than ever we need interventions to be based on evidence, not magical thinking."

Citing Russia as an example of mismatched interventions where IDUs represent 75% of those at risk yet only 20% are targeted, Dr. Bertozzi stressed the importance of targeted interventions for increased effectiveness.

Implementation efficiency can be improved. He noted the example of the variability of cost per client for pre- and post-test counselling, ranging from approximately \$7 per client in Russia to close to \$700 in Mexico. He asked whether the cost per patient on treatment for example, was known by national governments, across PEPFAR programmes, in World Bank-funded programmes or in Global Fund programmes. If there is extreme variability in costs it affords the opportunity to identify savings, he noted.

Twenty-seven years into the epidemic the focus remains on short-term results to deal with a long-term problem, resulting in a failure to give sufficient emphasis to long-term structural changes such as training more health care workers, empowering women or changing social norms. Evaluation of programme impact was also being given second place in emergency responses to getting programmes up and running, Dr Bertozzi argued.

Elizabeth Lule of the World Bank concurred and reiterated that the current crisis provides an opportunity to do better. She suggested questions that Ministers of Finance would ask as they review their budgets. Was there a decrease in mortality with people on treatment? Was there an increase in their productivity as a result? Did children return to school?

There is a need to convince the Minister of Finance that by investing in the social sector and in HIV that there would be huge payoffs: for example, an improvement in life expectancy and education.

Dr. Lule stressed the importance of governance and accountability: civil society and government bear mutual responsibility to ensure that the monies reach those who need it, she argued

She underscored the importance of measuring the impact of programmes and highlighted an absence of baseline data, a necessity for future sustainability. Such data are needed not only for the health system but also for procurement as well as fiduciary responsibility. She stressed that even if a government system is not working it cannot be ignored. Surveillance data are largely missing. While it is weak for all diseases it is particularly so for HIV, but surveillance is particularly critical for proper targeting

Coordination and harmonization, Dr. Lule noted, is not just for donors. It is also important between and among countries and regions. Regional integration will promote economies of scale for procurement and enable negotiation for scale-up.

#### **How to reduce the risk of programme interruptions in the event of a funding shortfall**

At the national level, planning to minimise the risks of programme interruption will include:

- 1 The development and implementation of National Strategic Plans (NSPs) and Operating Plans (OPs)
- 2 Good governance (e.g. transparency and elimination of corruption), and



### 3 Improved effectiveness and efficiency of programme delivery

The World Bank hosts the AIDS Strategy and Action Plan Program (ASAP) on behalf of UNAIDS and has created a specific Financial Crisis Impact Assessment Tool for HIV/AIDS (*FinCIAT*) to assist National Governments, notably Ministers of Finance, as they consider how to allocate emergency funding being put in place by the international community to respond to this financial crisis.

The Financial Crisis Impact Assessment Tool for HIV/AIDS (*FinCIAT*) has been designed specifically to help countries assess the impact of the crisis on their HIV/AIDS programmes. It is a flexible short-term tool with a simple 6-step approach allowing for identification of trade-offs among changes in programme activities. It can be as general or as detailed as necessary adaptable to different country conditions. With a focus on evidence and prioritization its aim is to enable identification of priority interventions that have to be maintained in this time of limited resources. Long-term use is also suggested to improve programme efficiency and effectiveness.

The current tool (dated May 28, 2009) is in draft form available for comment from users. [www.worldbank.org/asap](http://www.worldbank.org/asap) Comments on this draft may be sent to Jonathan Brown at the World Bank [jbrown3@worldbank.org](mailto:jbrown3@worldbank.org)

The steps include:

- 1 Evaluation of the current funding status enabling identification of gaps
- 2 Estimating the vulnerability of funding commitments
- 3 The funding status of programme activities
- 4 Reprioritisation and reallocation
- 5 Implementation of changes and negotiation
- 6 Monitoring, evaluation and revision – the identification of changes and their impact on programme outputs.

Stagnation is likely necessitating increased strategic and operational planning, better integration of HIV into other health and social programmes, increased efficiency of programmes more like the private sector and ultimately planning for success in the long-term.

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## Dr Kevin De Cock calls for end to suboptimal HIV care for resource-limited settings

By Theo Smart

"I do not raise the memory of Tuskegee lightly, but... the world cannot allow a permanently two-tiered system of global AIDS treatment, with late initiation of outmoded drugs reserved for the

South. Nor can we hide behind lack of knowledge or the attitude of 'let's wait and see'," said Dr Kevin M. De Cock, the exiting Director of WHO's HIV Department in the opening plenary address of the 2009 HIV Implementers' Conference. "Equipoise no longer exists in the debate about early or late initiation, and today's questions are 'treat how early?' and 'with what?'"

Dr De Cock is a highly esteemed researcher and infectious disease specialist with a longstanding engagement to global health, in particular HIV/AIDS, tuberculosis (TB) and other tropical diseases. He joined the WHO a little over three years ago, after years of working with the US Centers for Disease Control and Prevention (CDC) including six years as Director of the CDC in Kenya. During his tenure at WHO, he is perhaps best known for moving the HIV/TB agenda forward, for launching provider-initiated testing and counselling (PITC) and for the current movement to begin evaluating the effectiveness of universal HIV treatment as HIV prevention.

The man is first and foremost a scientist (his speech began by quoting President Barack Obama as saying "We will restore science to its rightful place and wield technology's wonders to raise health care's quality..."); and word is that this made his term at the highly political WHO a bit rocky at times. Consequently, in the time he has served at WHO, this was perhaps the most candid and powerful speech this reporter has ever heard him make – and it was clearly his swansong as the HIV Department Director. It tackled not only the increasing inequities in global treatment and uncertainties around treatment, but the failures of HIV prevention.

The entire talk and a link to the accompanying slides can be found online [here](#). This article covers some of the highlights and provides more context for some of Dr De Cock's key points.

## Epidemiology

"Despite emphasis on 'knowing your epidemic', it remains difficult to answer the simple, essential questions - of the last 1000 infections, in whom did they occur, how were they acquired, where, and from whom?" said Dr De Cock. He noted that modes of transmission vary widely from country to country – within Africa casual sex is the cause of most infections in some countries, but in those countries with the highest burden of HIV, most transmission is occurring within stable relationships.

"The proportion of HIV infections in Africa attributable to male-to-male sex is uncertain," he said to a mostly African audience, in a country where the previous President (and symbolic father of the country), Sam Nujoma only several years ago had called for purges of gays and lesbians. ("The Republic of Namibia does not allow homosexuality [or] lesbianism here," Nujoma had said. "Traditional leaders, governors, see to it that there are no criminals, gays and lesbians in your villages and regions.")

Although the current president, Hifikepunye Pohamba, doesn't engage in such hate speech, the wounds are still raw, and there appear to be no gay or lesbian venues in the country. Nonetheless, with many Namibian government officials in attendance, including the President and the whole of Namibia's parliament, Dr De Cock frankly said: "HIV in MSM in Africa not only needs urgent scientific and programmatic attention but should be a priority human rights issue: male-to-male sex is illegal in over half of all African countries, and in four is punishable by death."

Dr De Cock also pointed out the need to focus prevention efforts on women, especially pregnant women. "Almost 90% of HIV infections in pregnant women are found in just 20 countries, all but one in sub-Saharan Africa," he said, and he cited recent data from Botswana showing that many women are infected during pregnancy

or shortly thereafter. These infections were associated with high transmission rates, and accounted for an estimated total of 43% of all maternal transmissions in the PMTCT programme.

Dr De Cock stressed the high burdens of HIV/TB coinfection. "In 2007, there were about 1.4 million HIV-positive tuberculosis cases, representing 15% of global TB incidence. 26% of global TB deaths were estimated to be HIV-associated, and 23% of HIV deaths were likely from tuberculosis," he said, stressing that in the high burden countries of southern Africa the burden of coinfection is much greater.

Although the incidence of HIV transmission may have peaked in the last decade, the absolute number of people living with HIV continues to grow — particularly in Africa, which already had a disproportionate burden of HIV. Three million people with HIV in low- and middle-income countries are now receiving antiretroviral therapy (ART).

"However, at the end of 2007, 6.7 million people were in danger of their lives for lack of treatment, and 23 million were waiting, mostly unknowingly, to become treatment-eligible, sickened or die. With one million people newly on therapy but 2.7 million newly infected in 2007, treatment need continues to escalate. Without substantial reduction in HIV incidence, universal access risks becoming ever more remote," he said.

## Prevention

"Evidence-based prevention interventions are limited in number and efficacy, simple biomedical interventions are lacking, research findings are incompletely implemented, interventions are not targeted," said Dr De Cock. He noted that "every transmission event concerns two serologically discordant individuals," and yet fairly little attention has been paid to "prevention with positives."

Notably, another speaker suggested this could be because of the lack of engagement of people with HIV in designing such a response. Dr Kevin Moody of the Global Network of People Living with HIV (GNP+) said that during a recent technical consultation, people with HIV who were present "felt that the current definition of prevention with positives focuses too much on virus transmission and made people with HIV fully and wholly responsible for HIV prevention. In essence, we were seen as vessels of virus that needed to be contained. Instead, we wanted to see what positive prevention meant to us, our families and communities."

His group is promoting a new term: "positive health, dignity and prevention," that he feels could help provide for a more enabling policy and legal environment free of stigma and discrimination, a holistic approach to the health of people with HIV (including shared responsibility for HIV prevention), the active participation of most-at-risk groups, and self-determination for people with HIV. "In essence, people with HIV want to be seen as the solution to HIV and not the problem," he concluded.

Dr De Cock said that "for the magnitude of the problem, funding, political will and coverage are insufficient - consider, for example, access to science-based harm reduction for drug injectors or services for sex workers." He mentioned the new catch phrase 'combination prevention' which largely replaced the 'ABC' approach at the meeting this year. Combination prevention employs multiple disciplines and approaches, and encompasses individual and small group behavioural interventions, community and structural interventions, HIV testing linked to care, and biomedical interventions.

Dr De Cock then focused on testing. "Universal access is impossible without greatly increased knowledge of HIV status," he

said, and yet around 80% of people with HIV in low or medium-income countries are unaware of their status.

"And there's been inadequate attention to the prevention benefits of HIV testing," he said, citing a number of studies showing a reduction in unprotected sex among people who are aware of their status. He noted that in addition to provider-initiated testing and counselling (PITC) (which should be offered to all symptomatic patients; HIV-exposed children or children born to HIV-positive women and men seeking male circumcision for HIV prevention), there are a number of new approaches that could increase testing, including testing of partners and families; mobile and community testing; and door-to-door testing.

"Recently in Kibera - a large slum in Nairobi - home testing was offered to 7,000 people with 96 percent uptake," he said.

"Research on biomedical interventions to interrupt sexual transmission has been discouraging," he said noting that of 26 randomised controlled trials of different interventions, 22 failed to show efficacy — the only notable exception being male circumcision. However, earlier this year saw the first encouraging preliminary data from a human microbicide trial for PRO 2000; and preclinical data on topical as well as oral antiretroviral agents (pre-exposure prophylaxis or PREP) seem promising. But even should these approaches prove efficacious, it may be difficult to implement them.

"Assumptions are made about microbicides and women's control - these products are not necessarily that easy to use discreetly, store unobtrusively, or dispose of invisibly, potentially challenging for the most vulnerable. We need to discuss targeting of interventions to where infection incidence is highest - adolescent girls seem to be missed in these trials. Concerning PREP, it may take unusual persuasiveness to convince a decision-maker to give drugs to HIV-uninfected persons when many with declared HIV disease are dying from lack of access," he said.

He then focused on treatment as prevention, an issue that has recently led to much debate.

"The rationale is clear: transmission only occurs from infected persons; viral load is the major risk factor for all modes of transmission; ART lowers viral load; prevention of mother-to-child transmission offers proof of concept; and there is supportive observational evidence from discordant heterosexual couples," he said.

He cited a [modelling study published last December](#) that found that "in an epidemic of southern African severity, annual, universal voluntary HIV testing followed by immediate ART for those infected would reduce HIV incidence by 95% within a decade, reduce prevalence to below 1% within 50 years, and be cost-saving compared to current treatment scenarios after about 25 years." He stressed that this paper was not WHO policy, but was meant to stimulate research and discussion.

## Treatment guidelines

However it was the subject of HIV treatment guidelines that occasioned Dr de Cock's most forceful remarks.

WHO's HIV treatment guidelines are currently being revised, and Dr De Cock highlighted some of the major questions which need to be considered such as how best to diagnose and monitor, when to start ART, and the optimal nature of first and second-line regimens.

"We have long known of increased mortality in African patients on ART compared with outcomes elsewhere," he said citing data from Dr Steve Lawn and colleagues showing high rates of death in people with less than 200 CD4 cells and high rates of TB and TB-related death in people with less than 500 CD4 cells. "Although

mortality rates at the higher levels may be relatively low, applied to large numbers of people living with HIV, this converts into many absolute deaths... A conclusion would seem that if the future is to be different, we have to intervene earlier, before people with HIV fall into or spend too long in these CD4 danger zones for death and tuberculosis," he said.

"The question of when to start ART is actually two questions, when to start in relation to acute opportunistic events, and when to start according to CD4 staging. The emerging evidence suggests ART should be initiated as soon as possible in acute [opportunistic] illness," said Dr De Cock. Likewise, he cited recent data demonstrating that the risk of mortality increases with falling CD4 cells — and that these risks are substantial even at relatively high CD4 cell starting points (for example between 350-500 cells).

"Just on Monday this week, results of an NIH-sponsored randomised controlled trial in Haiti showed that starting ART at CD4+ counts between 200 and 350 yielded substantially better outcomes than deferring treatment till counts dropped below 200," he said.

[The study, CIPRA HT 001](#), was in over 800 subjects and began in 2005. By the time of a data safety and monitoring board interim review, six people in the early treatment group had died, compared to 23 people in the standard-of-care group— nearly a four-fold difference. Among participants who began the study without tuberculosis (TB) infection, 18 people in the early treatment group developed TB, while 36 people — twice as many — in the standard-of-care group had developed TB. The study was ended immediately, and all the participants were offered treatment.

"Changing starting criteria has major implications for cost and choice of drugs. Starting at a CD4 count of 350/mm<sup>3</sup> in countries like Kenya or Zambia will double treatment need," Dr De Cock said.

He noted that other changes to make treatment more comparable to that in industrialised countries — such as moving away from the drug d4T, which is rarely used in the North, to the easier to tolerate tenofovir, would also cost more money (tenofovir currently costs four times more). (Later in the conference, during a session on pharmacovigilance, angry clinicians yelled at a representative of WHO for the lack of clarity in the current guidance about whether d4T was too toxic to use. "Should we get rid of it or not?" one doctor asked).

Notably, Dr De Cock said that when the current four-drug TB regimen was chosen, "drugs with unacceptable toxicity such as thiacetazone were phased out because collectively we said "Enough, now," even as some argued against change citing cost or drug resistance."

Expanding ART access for pregnant women, particularly for those who are breastfeeding, is also an issue that needs to be considered in new guidance. However, Dr De Cock pointed out:

"It is tempting to look to revision of guidelines as the answer - but patients don't read guidelines, and guidelines don't build health systems. Late diagnosis and weak maternal and child health services are more important barriers than lack of guidance. PMTCT depends on the same systems that are failing to deliver on MDG 5 — the reduction in maternal mortality — which is highest in Africa, unchanged over the last two decades and one of the greatest disparities in global health. Maternal mortality may be the analogous single most important indicator for the future of AIDS in women and children, perhaps for global health overall," he said.

## The future of universal access and the arc of history

"There is more, a lot more, to AIDS than just technical work," said Dr De Cock and citing Martin Luther King's famous quote "the arc of the moral universe is long but it bends towards justice," he described what should be the philosophical basis for AIDS work.

"If public health is rooted in the science of epidemiology, its philosophic values are equity and social justice. We are entering perilous ethical and political waters, and current practice for poor people of colour in the global South will not be judged well by history if it does not evolve with science and practice in the richer North," he said.

Dr De Cock then invoked the Tuskegee experiment. He said that others would certainly draw analogies between the current practice of care the world was offering millions of people with HIV in resource-limited settings — failure to diagnose most, and late and sub-optimal treatment to the remainder — and Tuskegee, the most infamous biomedical experiment ever in the US, in which poor African-American men with syphilis were left untreated. It is important to note that this was not so unreasonable when the study began in the 1930's — the existing treatments at the time were toxic and of dubious benefit — and participants would get them after several months of observation anyway. But soon the money for treatment ran out, and the study continued anyway. In the 1940s, a highly effective treatment, penicillin, became available, but the researchers not only failed to provide treatment, they withheld information about treatment. The study only ended decades later after a whistleblower brought it to the attention of the media — after many men had died, passed the infection on to their wives, and had children with congenital syphilis.

Just like Tuskegee, there is no longer any question that earlier treatment in Africa would save lives — even though how early and the optimal regimen are unclear. But Dr De Cock said that with millions of people in these programmes, the world ought to be able to do research to find the answer — and he proposed conducting a large simple trial with the support of PEPFAR and the Global Fund.

"It is unacceptable, in view of what is at stake - millions of lives, billions of dollars - that despite over 3 million people in the world on ART, we cannot definitively answer the question of when to start treatment. There is ethical as well as medical need for a randomised controlled trial to determine optimal starting criteria in Africa, including assessment of the impact of immediate treatment on tuberculosis incidence. PEPFAR and the Global Fund could resolve these questions once and for all through applied research under field conditions, through a large simple trial, for example, with hard endpoints such as tuberculosis, AIDS, death. Some argue such a study is not needed because we will never have resources to treat more people earlier with better drugs. This is unpersuasive; rationing of health care is a universal reality but let rationing decisions be made transparently, with the involvement of all stakeholders, based on scientific understanding of cost and benefit," he said.

Ultimately, Dr De Cock believes that HIV treatment should go the way of TB treatment with one, or a few, global, once-daily, first-line regimens containing "the best drugs"

"That it can be done was shown by the tuberculosis community a decade ago. Today, if you get tuberculosis in Jakarta, Kampala or Los Angeles, you receive the same four-drug regimen," he said.

Doing all this may take “imaginative thinking, renewed advocacy, innovative financing, and more efficient implementation.”

“Global health needs global financing,” Dr De Cock said.

“Raymond Biggs, New York Commissioner for Health a century ago, famously said that public health is purchasable and every society can determine its own death rate.”

“Universal access will slip through our fingers unless we reframe it in the broader context of all health-related Millennium Development Goals. From disjointed prevention and treatment of the past we must move towards more intelligent use of ART for treatment as well as prevention, guided by science, stratified by individual serostatus, with all infected persons knowing their rights to health, including sexual and reproductive health. What else is universal access?” he said.

Finally he concluded by quoting Robert Kennedy, ‘Only those who dare to fail greatly can ever achieve greatly.’

“That is the spirit of PEPFAR and the Global Fund. And for all here working on the front lines, far from the halls of power, remember that all public health is local and change is often driven from small places - places that you may not find on any map of the world, but where ordinary people take risks. There is comfort in those other words of Robert Kennedy: ‘Few will have the greatness to bend history itself; but each of us can work to change a small portion of events, and in the total of all those acts will be written the history of this generation.’

“To which one could add: And so also, one day, will be written the history of this pandemic.”

## about HATiP

A regular electronic newsletter for health care workers and community-based organisations on HIV treatment in resource-limited settings.

The newsletter is edited by Theo Smart (Cape Town) and Keith Alcorn, NAM's Senior Editor (London).

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