

Epilogue

Many arguments have been raised over the past decade to justify not moving rapidly forward with ART programs in settings with limited resources. The standard litany of objections has included the price of therapy, the complexity of the intervention, the inadequacy of health infrastructure, and the staggering lack of trained health care providers. For years such arguments were supported by cost-effectiveness analyses and the false dichotomy of prevention versus treatment. The cumulative effect of these arguments was to allow the death of tens of millions of poor people in developing countries who were living with and becoming ill as a result of HIV infection. The statistics were unambiguous: more than 90 percent of HIV infections occurred in the developing world, 75 percent in sub-Saharan Africa alone; tuberculosis epidemics were fanned by HIV; fragile health infrastructures were overwhelmed.¹ By 2002, perhaps 1 percent of all sub-Saharan Africans needing ART were receiving it, and many ostensibly on therapy were unable to acquire their medications regularly.² In Africa alone, an estimated 14 million children had lost one or both parents to AIDS.³ Prevention efforts were hampered by stigma: who wanted to be tested for a disease for which treatment was in effect unavailable? Meanwhile, in countries rich in resources, the efficacy of antiretroviral therapy has been well-confirmed: in the United States, ART has prolonged life by an estimated 13 years⁴—a success rate that would compare favorably with that of almost any treatment for cancer or complications of coronary artery disease.

The inequity between rich and poor countries in terms of access to HIV treatment has at last reached the public consciousness and rightly given rise to widespread moral indignation. A few outstanding leaders have been consistent and courageous in their personal and public stances. The national AIDS treatment program in Brazil, for example, has long demonstrated what

can be achieved when there is unswerving political commitment and public health leadership. As documented in this manual, Partners In Health has worked with the Haitian and Rwandan Ministries of Health to launch and scale-up comprehensive AIDS treatment programs in those countries, ensuring that provision of primary care is part of the disease treatment model. Other innovative projects pioneered by NGOs in diverse settings have clearly established that a very simple approach to ART, underpinned by intensive community engagement and support, can achieve remarkable results.

In 2003, fueled by the momentum of these diverse efforts, the World Health Organization, together with the Joint United Nations Program on HIV/AIDS (UNAIDS), launched the “3 by 5” initiative, setting the ambitious goal of putting three million people in the developing world on antiretroviral therapy by 2005.⁵ There was no prior experience to draw upon because there had never been an attempt to provide, across national borders and in some of the poorest places in the world, lifelong suppressive therapy for a chronic infection. Although the 3 by 5 initiative did not achieve its ambitious overall target, under its aegis ART coverage in developing countries has more than doubled, and scale-up appears to be accelerating. Treatment algorithms have been standardized, and intensive training packages for health and community workers have been developed and implemented in many countries. Overall, most African countries report that demand for treatment is outstripping their capacity to supply it, underlining the urgent need for increased resources and technical support in order to maintain this momentum. And at the G8 meetings in Scotland in 2005, the final communiqué pledged a commitment to providing universal access to HIV treatment by 2010.

In the wake of these recent developments, a very different picture—and different expectations—has emerged. Billions of dollars of funding from the Global Fund to Fight AIDS,

Tuberculosis and Malaria and the U.S. President's Emergency Plan for AIDS Relief has helped to launch hundreds of treatment projects since the last conference in 2004, and many will be discussed in Toronto for the first time. For example, the Bill & Melinda Gates Foundation and Merck & Co., working with officials in Botswana, have begun to offer universal access to ART in one of the world's most severely HIV-affected countries. The policy and action implications of the lessons learned from these efforts, five of which are detailed below, need to be front and center. Based on my experience in setting global AIDS policy, on the one hand, and implementing integrated projects in settings of extreme poverty, on the other, I believe that ambitious policy goals, adequate funding, and knowledge about implementation can move us toward the elusive goal of shared hope.

The first lesson is that selling AIDS prevention and care will pose insurmountable problems for those living in poverty, as there will always be those unable to pay even modest fees for services or medications, whether generic or branded. AIDS care should be seen, as is the case for airborne tuberculosis, as a public good for public health.⁶ Policy makers and public health officials, especially in heavily burdened regions, should adopt universal-access plans and waive fees for HIV care. The advent of generic medications, thanks to efforts by groups such as Médecins Sans Frontières and the Clinton Foundation,⁷ means that ART can now cost less than 50 cents a day, and costs continue to decline to levels that developing-country public health officials can hope to pay for their citizens. Furthermore, all first-, second-, and even third-line antiretroviral medications must be made available at these now-affordable prices. Generic manufacturers in China, India, and other developing countries stand ready to provide the full range of drugs. Whether through negotiated agreements or use of the full flexibilities of the TRIPS agreement, full access to all available antiretroviral drugs must quickly become the standard in all countries.

Second, effective scale-up of pilot projects will require strengthening and even rebuilding health systems. In previous years, a lack of health infrastructure has been labeled a barrier to ART; we must now marshal AIDS resources, which are at last considerable, to rebuild public health systems in sub-Saharan Africa and other HIV-burdened regions. These efforts will not weaken attempts to address other ranking problems—malaria, maternal mortality, vaccination undercoverage, other diseases of poverty—if they are planned deliberately, with the public sector in mind. Only the public sector, not NGOs, can offer health care as a right.

Third, AIDS funding offers us a chance to stop and even reverse the “brain drain,” long cited as a reason that we cannot treat AIDS in the poor world. In addition to recruiting physicians and nurses to underserved regions and providing them with the tools of their trade, we must also train community health workers to supervise care, for AIDS and many other pathologies, in their home villages and neighborhoods. This should be done even if there is an abundance of physicians, since community-based, closely supervised care is simply the highest standard of care for chronic disease. This is as true in the first world as it is in the third. Also, community health workers must be compensated for their labor if these programs are to be sustainable over time.

Fourth, extreme poverty makes it difficult for many patients to comply with ART. Indeed, poverty is far and away the greatest barrier to scale-up of treatment projects. In many rural regions of Africa, hunger is the major “co-morbid disease” seen with both AIDS and tuberculosis, and these consumptive diseases cannot be treated effectively without food supplementation. Coordination between initiatives such as PEPFAR, the Global Fund, and the U.N.’s World Food Program can help in the short term; fair trade agreements and support of African farmers will help in the long run.

Fifth, investments in global AIDS and tuberculosis are much more generous than they were only five years ago, but these investments must be increased and sustained if we are to slow these ever more complex epidemics. One of the most ominous recent developments is the advent of highly drug-resistant strains of both diseases. “Extensively drug-resistant tuberculosis,” or XDR TB, has been reported in the United States, eastern Europe, Asia, South Africa, and elsewhere; in each of these settings, HIV has amplified local epidemics of these almost untreatable strains.⁸ These tuberculosis strains cannot be wished away, and XDR HIV will surely follow. Only massive efforts to diagnose and treat these diseases ethically and effectively will stem these epidemics. We have already learned a great deal about how best to expand access to second-line antituberculous drugs while at the same time increasing control over their use;⁹ these lessons, too, must be applied in the struggle against AIDS and other infectious pathogens.¹⁰

Finally, there is a need for a renewed commitment of basic science to vaccine development, more reliable diagnostics—those widely used to diagnose tuberculosis are neither specific nor sensitive, which is unsurprising since they were developed a century ago—and novel classes of therapeutics. The research-based pharmaceutical industry has a critical role to play in drug development, even if the overall goal is a segmented market with higher prices in developed countries and generic production with affordable prices for developing countries. There has also been a heartening increase in basic science investments for tuberculosis and malaria; National Institutes of Health (NIH) funding for HIV research remains robust. Yet the fruits of such research will not arrive in time for those now living with, and dying from, AIDS and tuberculosis.

The past two years have shown us that we can make these services available to millions, even in the poorest reaches of the world. The unglamorous and difficult process of increasing

access, to prevention *and* care, needs to be our primary focus if we are to move towards the lofty goal of equitably distributed medical services in a world riven by inequality. The model of care beautifully presented in this volume offers great promise in moving us toward that goal.

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September 2006

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