



AIDS in 2006 — Moving toward One World, One Hope?

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For the past two decades, AIDS experts — clinicians, epidemiologists, policymakers, activists, and scientists — have gathered every two years to confer about what is now the world's

leading infectious cause of death among young adults. This year, the International AIDS Society is hosting the meeting in Toronto from August 13 through 18. The last time the conference was held in Canada, in 1996, its theme was “One World, One Hope.” But it was evident to conferees from the poorer reaches of the world that the price tag of the era's great hope — combination antiretroviral therapy — rendered it out of their reach. Indeed, some African participants that year made a banner reading “One World, No Hope.”

Today, the global picture is quite different. The claims that have been made for the efficacy of antiretroviral therapy have proved to be well founded: in the United States, such therapy has prolonged

life by an estimated 13 years¹ — a success rate that would compare favorably with that of almost any treatment for cancer or complications of coronary artery disease. In addition, a number of lessons, with implications for policy and action, have emerged from efforts that are well under way in the developing world. During the past decade, we have gleaned these lessons from our work in setting global AIDS policies at the World Health Organization in Geneva and in implementing integrated programs for AIDS prevention and care in places such as rural Haiti and Rwanda. As vastly different as these places may be, they are part of one world, and we 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 charging for AIDS prevention and care will pose insurmountable problems for people living in poverty, since there will always be those unable to pay even modest amounts for services or medications, whether generic or branded. Like efforts to battle airborne tuberculosis, such services should be seen as a public good for public health. Policymakers and public health officials, especially in heavily burdened regions, should adopt universal-access plans and waive fees for HIV care. Initially, this approach will require sustained donor contributions, but many African countries have recently set targets for increased national investments in health, a pledge that could render ambitious programs sustainable in the long run.

As local investments increase, the price of AIDS care is decreas-



Haitian Patient, before and after Receiving Free Treatment for HIV Infection and Tuberculosis.

The photograph on the left was taken in March 2003, and that on the right in September 2003. Many impoverished patients in rural Haiti and Rwanda now receive comprehensive medical care through public-private partnerships.

ing. The development of generic medications means that antiretroviral therapy can now cost less than 50 cents per day, and costs continue to decrease to affordable levels for public health officials in developing countries. All antiretroviral medications — first-line, second-line, and third-line — must be made available at such prices. Manufacturers of generic drugs 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 Agreement on Trade-Related Aspects of Intellectual Property Rights, full access to all available antiretroviral drugs must quickly become the standard in all countries.

Second, the effective scale-up of pilot projects will require the strengthening and even rebuilding of health care systems, including those charged with delivering primary care. In the past, the lack of a health care infrastructure has been a barrier to antiretroviral therapy; 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 efforts to address other problems — malaria and other diseases of poverty, maternal mortality, and insufficient vaccination coverage — if they are planned deliberately with the public sector in mind.² Only the public sector, not nongovernmental organizations, can offer health care as a right.

Third, a lack of trained health care personnel, most notably doctors, is invoked as a reason for the failure to treat AIDS in poor countries. The lack is real, and the brain drain continues. But one reason doctors flee Africa is that they lack the tools of their trade. AIDS funding offers us a chance not only to recruit physicians and nurses to underserved regions, but also to train community health care workers to supervise care, for AIDS and many other diseases, within their home villages and neighborhoods. Such training should be undertaken even in places where physicians are abundant, since community-based, closely supervised care represents the highest standard of care for chronic disease,³ whether in the First

World or the Third. And community health care workers must be compensated for their labor if these programs are to be sustainable.

Fourth, extreme poverty makes it difficult for many patients to comply with antiretroviral therapy. Indeed, poverty is far and away the greatest barrier to the scale-up of treatment and prevention programs. Our experience in Haiti and Rwanda has shown us that it is possible to remove many of the social and economic barriers to adherence but only with what are sometimes termed “wrap-around services”: food supplements for the hungry, help with transportation to clinics, child care, and housing. In many rural regions of Africa, hunger is the major coexisting condition in patients with AIDS or tuberculosis, and these consumptive diseases cannot be treated effectively without food supplementation.⁴ Coordination among initiatives such as the President’s Emergency Plan for AIDS Relief, the Global Fund to Fight AIDS, Tuberculosis, and Malaria, and the World Food Program of the United Nations can help in the short term; fair-trade agreements and

support of African farmers will help in the long run.

Fifth, investments in efforts to combat the global epidemics of AIDS and tuberculosis are much more generous than they were five years ago, but funding must be increased and sustained if we are to slow these increasingly complex epidemics. One of the most ominous recent developments is the advent of highly drug-resistant strains of both causative pathogens. “Extensively drug-resistant tuberculosis” has been reported in the United States, Eastern Europe, Asia, South Africa, and elsewhere; in each of these settings, the copresence of HIV has amplified local epidemics of these almost untreatable strains. Drug-resistant malaria is now common worldwide, extensively drug-resistant HIV disease will surely follow, and massive efforts to diagnose and treat these diseases ethically and effectively will be needed. We have already learned a great deal about how best to expand access to second-line antituberculous drugs while increasing control over their use⁵; these lessons must be applied in the struggles against AIDS, malaria, and other infectious pathogens.

Finally, there is a need for a

renewed basic-science commitment to vaccine development, more reliable diagnostics (the 100-year-old tests widely used to diagnose tuberculosis are neither specific nor sensitive), and new 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 in developing countries.

There has been a heartening increase in basic-science investments for tuberculosis and malaria; funding for HIV research at the National Institutes of Health remains robust. Yet the fruits of such research will not arrive in time for those now living with, and dying from, AIDS and tuberculosis. New tools to prevent, diagnose, and treat the diseases of poverty will be added to the stockpile of other potentially lifesaving products that do not reach the poorest people, unless we develop an equity plan to provide them. Right now, our focus must be on improving access to the therapies that are available in high-income countries. The past few 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 toward the lofty goal of equitably distributed medical services in a world riven by inequality. Without such goals, the slogan “One World, One Hope” will remain nothing more than a dream.

An interview with Dr. Farmer can be heard at www.nejm.org.

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Changing the Paradigm for HIV Testing — The End of Exceptionalism

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The Centers for Disease Control and Prevention (CDC) is poised to issue new recommendations for testing for HIV in adults, adolescents, and pregnant women. Frustrated that more than 25 percent of Americans with HIV infection are unaware of their status and that almost 40 percent of

those with newly diagnosed AIDS discover that they are infected less than a year before diagnosis, officials have proposed that HIV screening be routinely offered in all health care settings.

The CDC already recommends routine testing among high-risk groups and in high-prevalence set-

tings. The radical departure is the extension of routine testing to the entire population and the reconceptualization of the requirements for consent. Patients would be told that HIV testing was a routine part of care and given the opportunity to opt out. According to the CDC, specific signed consent would no