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Introduction to the aidsfocus conference

Treatment and care for all

Von Claudia Kessler Bodiang

"When 'treatment and care for all' is discussed within the frame of this conference we should keep in mind that at the core we are talking about people, about human suffering, about inequities, inequalities and injustice." - A brief introduction to some of the issues discussed throughout the aidsfocus-conference on April 20, 2004, in Berne.

We should keep in mind that our debates take place at a time when "the Millennium Development goals are being held hostage by AIDS", as Stephen Lewis, the UN special envoy for HIV/AIDS in Africa put it. We should recognize that we are at a turning point in the history of AIDS, where it is no longer a question about whether poor people living in resource limited countries should or should not have access to treatment and care.

As Paul Farmer put it, cost effectiveness is not the only criteria: "We don't know how much it costs us as human beings not to have equity - to have a situation in which some people have access to drugs and others don't." Today, we consider it a basic human right to get access to treatment and care for HIV and AIDS, independently of where a person lives on this planet.

There are today 6 million people in need of antiretroviral treatment (ART), out of an estimated 42 million HIV infected people world-wide. More than 70% of all infected people live in Sub Saharan Africa, where today less than 2% of those in need (50 - 100 000 people) receive antiretroviral treatment. Low coverage of ART, just as HIV/AIDS itself, is closely linked to the poorest countries.

It is important to highlight that when this conference talks about access to treatment, we talk about only one component within a very complex and comprehensive continuum of prevention to treatment, care and impact mitigation. Crucially, scaling up access to treatment and care should not go at the expense of prevention, which has proven to be highly effective in curbing the epidemic in many countries in the North and the South.

In the centre of our discussion are people and communities who need support from health services and systems with a very wide range of services, from their psychosocial environments and socio-economic factors, from and human rights and legal systems. For this support to be effective, it needs a conducive policy and social environment that is free of stigma.

The International HIV/AIDS Alliance uses a jigsaw to visualise all the complex dimensions that need to go together, showing that there is much more to scaling up ART than the issues of antiretroviral drugs. In addition to health services being one piece in the puzzle, a comprehensive approach to treatment and care looks at:

- Stigma and discrimination
- Multisectoral approach
- Home visits
- Home based care
- Information, Education and Communication (IEC)
- Counselling
- Training
- Groups of people living with HIV/AIDS, etc.

Looking at the opportunities, we do have today the advantage that ”we know it works, we know what works and we know what doesn't”, as Milly Katana, an AIDS activist, put it. There are today effective antiretroviral treatments. Brazil has shown how, by using a human rights approach to prevention and treatment, it was able to cut deaths due to AIDS by half since 1996. Quite a number of pilot approaches, many of them run by NGOs, have demonstrated that antiretroviral treatment can work in the poorest countries. There is also evidence today, that results of treatment and adherence in resource limited settings can be equal to those in developed countries. Thanks to the lower prices of generic fixed dose combination drugs (FDC) it is possible today to treat four times the number of people compared to the number that could be treated with brand name drugs. With Brazil and India as pioneers, many African countries have started now or are preparing to produce generic drugs locally (South Africa, Mozambique, Namibia, Ethiopia, Zimbabwe, etc).

Thanks to the introduction of generic drugs and many other efforts, the prices for ARV drugs have dropped significantly from approximately 8000 US$ per patient and year in 2000 to as low as 20 US$ per patient and month by now.

However, despite these drops in drug prices, the Kenyan example shows that for many countries access to treatment is still an unaffordable challenge. Treating a quarter of the patients in need would cost Kenya seven times the current government spending on health, or 6,3 % of its GNP.

There is today a strong international commitment to implement access to treatment in the most affected countries, with important flows of funding from:

- International funding initiatives, such as the Global Fund to fight AIDS, tuberculosis and malaria, the Clinton or Bill Gates Foundation and The World Bank. There are supporting governments, who are also increasing their budget allocation to HIV/AIDS.
- The World Health Organisation's "3 by 5" initiative, with the objective to co-ordinate and provide technical guidance needed when countries intend to scale up access to treatment.
- Strong lobby and advocacy groups of people, often infected or affected themselves, who play a vital role in the response to HIV and AIDS. These lobby groups have crucially contributed in developed countries to strengthen commitment and curb the epidemic.

These examples show that today, we do have a lot of opportunities - but we nevertheless still face huge challenges.

Despite the many efforts, so far we see a very slow roll-out of ART and have only minute numbers of patients under treatment: South Africa, for example, only just started to offer antiretroviral treatment in the public system. Overall, there are today only 20 000 people benefiting from ART in South Africa. In Tanzania, in December 2003, there were only 2000 out of 400 000 patients in need that received treatment, in Mozambique it were only 2000 out of more than 50 000 patients in need. There are many reasons for these insufficiencies, some of the most urgent challenges being:

- Money
- Health system capacity
- Equity
- Stigma

Although there is agreement that it is not only money that is missing, money certainly is an issue. Some examples: The Botswana government is currently paying about 7 - 10 000 US$ per patient under treatment each year (including the costs for additional infrastructure). As a result of rolling out antiretroviral treatment, Tanzania's biannual health budget is expected to almost triple in only three years (increasing from 25 million US$ in 2003/4 to 60 million US$ in 2006/7).

Governments are not able to cover these needs merely by reallocating budgets and "additional money" is clearly needed. The big global initiatives (GFATM and the WHO "3 by 5" initiative) are grossly underfunded. Often, donor pledges do not materialise in actual disbursements. These funds have proven to be highly unpredictable and little sustainable for the local governments.

Finally, the poorest are those who have to pay: A study of 728 HIV/AIDS affected households in South Africa shows that in rural areas poor families spend on average 54% of their monthly income on health care through direct payments.

Apart from the lack of commitment of donor governments there is insufficient political leadership of many local governments and public health systems are weak. Disregarding the additional burden of HIV/AIDS, many of these health systems were already facing significant problems of performance, coverage, equity and quality. The main challenges faced by health systems with regard to antiretroviral treatment result from a lack of equipment, provision of continuous and safe drug supply and the difficulty to integrate these new services without depleting the existing essential services.

For example, a recent Kenyan study shows that while doctors throughout the country are prescribing antiretroviral drugs, only 30% of them have received any training in administering and monitoring ART, and outside the capital Nairobi no laboratory facilities are available for monitoring the progress of therapy.

In addition, decades of macroeconomic measures, structural adjustments and health reforms have pushed countries into cutting spending on health and reducing their health work force. Tanzania, for example, has just "successfully" diminished their overall health sector workforce by more than 19'000 staff (1994-2002).

At the same time, in order to provide 65'000 PLWA with antiretroviral treatment by 2005, the country would need an estimated additional force of 12'000 qualified health workers. This at a time, where many of the health workers are themselves suffering and dying from HIV/AIDS. It is this lack of qualified human resources necessary to ensure access to treatment which is increasingly recognised as one of the major challenges in scaling up ART.

There are also many equity considerations linked to scaling up antiretroviral treatment. The poor have less access (for geographic, financial or educational factors) to ART, they have to wait longer, receive fewer drugs and pay higher shares of their incomes for treatment (South Africa). There is also an important issue of who should be given priority when it comes to distributing the limited treatments available. Medical criteria alone do not suffice when it comes to patient selection.

There is also an issue of equity related to gender. According to a recent report by Equinet and Oxfam, women in southern Africa are not only more vulnerable to HIV/AIDS and bear more of the impact, they are also highly disadvantaged when it comes to benefiting from the existing treatment programmes. Other reports from Botswana and other countries also show that very few women demand VCT and treatment services due to the huge stigma that is still attached to HIV/AIDS.

Stigma remains a challenge to scaling up ART for women, men and children. But it is also with regard to stigma that ART can benefit other components of a comprehensive approach. Scaling up ART can effectively reduce stigma and it can strengthen prevention and weak health systems.

At the beginning of the epidemic, HIV/AIDS was considered a health problem. We have succeeded coming a long way to accept that HIV/AIDS is a multisectoral problem that needs to be fought by all actors, at all levels. It is important to take care now that the rush for scaling up antiretroviral treatment does not create a backlash and leads to a remedicalisation of HIV/AIDS. People living with HIV/AIDS do need access to these treatments. But they and their countries also have many other needs that should not be forgotten. The problem of access to ART cannot be solved quickly, by vertical approaches, as it needs a strengthening of public health systems to become more equitable, accessible and sustainable.

As Alan White side said: "In Africa we need to see some rolling out of policy and some courageous and innovative rolling out of treatment - but it is not going to happen soon, and it is not going to happen for all that many people." But, although "we know we're not going to meet the goal, but it doesn't mean we should stop trying" (Paul Farmer).

Claudia Kessler is a physician and a Public Health specialist working for the Swiss Tropical Institute's Swiss Center for International Health. She has been involved in the planning of the aidsfocus platform since the very beginning of this project, and is a member of the Steering Committee of aidsfocus.ch. Contact: claudia.kessler@unibas.ch. The PowerPoint slides of this introduction are available on the conference website.

Some STI and SDC documents on HIV/AIDS Treatment and Care

Scaling up the Provision of Antiretroviral Treatment in resource poor settings (with a geographic focus on sub-Saharan Africa)
Authors: Helena Shang and Claudia Kessler Bodiang for SDC (2004)

Scaling up Antiretroviral Treatment and Human Resources for Health: what are the challenges in Sub Saharan Africa
Author: Kaspar Wyss for SDC (2004)

HIV/AIDS Background Information for International Cooperation
Authors Clara Thierfelder and Claudia Kessler Bodiang for SDC. This background paper aims to provide an overview for non specialized readers working in different sectors and at various levels. (2003, also available in German and French)

SDC HIV/AIDS Newsletter
"We plan to produce such a newsletter four times a year. This medium lives through interaction. You are invited to send us your suggestions, requests and information flashes. We particularly welcome contributions from Francophone Africa, Eastern Europe and Central Asia as well as Latin America. The editors are grateful for any contribution received!" The Newsletter team: Sandra Bernasconi, Swiss Agency for Development and Cooperation SDC, SoDev/Health; Claudia Kessler and Ricarda Merkle, Swiss Tropical Institute. Contact: claudia.kessler@unibas.ch

All documents are available on www.sdc-health.ch (Topic HIV/AIDS)

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