## Scaling up antiretroviral treatment in resource-poor settings

Anthony Harries and colleagues (June 3, p 1870)[1] do well to explore the tensions between technical and public-health approaches to the HIV/AIDS epidemic in Malawi. However, they miss opportunities to discuss several fundamental issues.

Important lessons could be learned from neighbouring countries. In Mozambique, the antiretroviral treatment (ART) scale-up programme is very similar to that of Malawi, using HIV day hospitals as the focus of care for HIV-positive people. However, these specialised treatment centres for HIV/AIDS have created problems of two-way discrimination. On the one hand, many HIV-infected patients are reluctant to approach the HIV services for fear of discrimination. But on the other hand, patients who are not HIV-positive are silently denied adequate general medical care as resources become diverted towards HIV-related illnesses.

In a country where 10% or more of the population are infected with HIV, real scale-up will occur not by simplifying procedures as Harries and colleagues propose, but by tackling the fundamental problem of vertical programmes. Shouldn't we be discussing decentralised testing, counselling, and care in peripheral health centres and health posts, where HIV services can be totally integrated into the primary health-care service and as a result begin to overcome the two-way discrimination that is inevitable in vertical ART programmes?

I declare that I have no conflict of interest.

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1 Harries AD, Schouten EJ, Libamba E. Scaling up antiretroviral treatment in resource-poor settings. *Lancet* 2006; **367:** 1870–72.

We recently returned from a fact-finding mission in Malawi to assess the state of laboratory infrastructure and capabilities for monitoring antiretroviral therapy (ART), as part of a new initiative at Imperial College of Medicine, London, UK, to develop simple, low-cost, robust, and rapid tests for measuring CD4 counts in HIV-positive patients in resource-poor settings.

What we found on our trip was that very few facilities were doing CD4 testing and even the settings that had flow cytometers on site faced shortages and interruption of reagent supplies, equipment breakdown, interruption of refrigeration and electricity, and other obstacles that will make CD4 testing, and indeed the use of viral load, completely impractical for the foreseeable future. We therefore agree with Anthony Harries and colleagues[1] that adoption of flow cytometry and PCR for monitoring patients on ART will lead "to the demise of the country's ART programme", since a requirement that these tests be done on most patients is simply unrealistic.

As part of preparations for the Imperial CD4 initiative, we also did a survey of ART sites in three dozen countries around the globe and found quite similar problems in laboratory infrastructure and capabilities. To scale up ART in the developing world and decentralise AIDS care out of capital cities, the public-health approach used in Malawi needs to be adopted more widely, although each country will have to find an approach for delivery of services that makes the most sense given its particular setting and available resources.

Integrating laboratory monitoring in ART programmes will either require new kinds of test that can be done without complex instrumentation, by non-laboratory staff (eg, nurses, health surveillance assistants), at a very low cost, and that can withstand the environmental conditions prevalent in these settings, or a vast improvement in laboratory infrastructure and capabilities in developing countries, both of which conditions remain unmet at the current time.

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Anthony Harries and colleagues provide a valuable contribution to the debate on strategies for scaling up antiretroviral therapy.[1] However, we feel that they overlook a critical lesson from the history of HIV/AIDS treatment in the developing world: cost and complexity of treatment are barriers that can, and must, be challenged.

The paper points to major threats to sustainable antiretroviral roll-out: insufficient funding and staff, patient overload, high-cost medicines, and complexity of laboratory monitoring. Although these threats are real, it is worth noting that these same threats were cited as arguments against scale-up of first-line therapy.[2]

If second-line drugs are too expensive, costs must be lowered. If pill burden threatens good adherence, fixed-dose combinations and better second-line drugs must be developed. We must advocate for tools better adapted to field realities, for better staff salaries, and further empowerment of nurses, clinical officers, affected individuals, and communities. These are not utopian ideals. According to WHO, Chinese generic antiretrovirals could render second-line treatment as affordable as first-line;[3] further fixed-dose combinations are in development, and simplified methods of measuring CD4 count[4] and viral load[5] are becoming available.



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We wholeheartedly endorse the call for simplicity to maximise access to essential health care in the face of limited resources. First-line rollout is the priority, but barriers that exclude access to second-line drugs must not be taken for granted. Affordable, two-pills-a-day triple therapy is only available thanks to strong political advocacy and a refusal to accept that antiretroviral therapy was unattainable. The same logic, however idealistic it might currently seem, must be applied to ensure that patients for whom first-line treatment fails are not denied a second chance.

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## Coordinating HIV control efforts

Roger England (May 27, p 1786)[1] is right to press for more accountability and a stronger focus of resources on priorities. But he is inconsistent in laying the blame for many of the missed priorities and wasted efforts on national AIDS commissions (NACs), when in reality the bulk of resources do not go through the hands of NACs at all. He seems to point the finger of blame only at the failure of national public institutions, and not see the challenges posed by the practices of international partners in a crowded institutional landscape. Privatisation as suggested by England in low-capacity countries does not guarantee better performance.

We suggest what is needed is for national AIDS authorities to develop prioritised and costed AIDS plans that are aligned with national development plans, with the goal of scaling up towards universal access to prevention, treatment, care and support. Civil society and vulnerable groups should be fully engaged in developing national plans, and countries should ensure the accountability of all partners through transparent peer review mechanisms for monitoring of processes and targets.

We must be more rigorous in applying existing commitments: the Three Ones Principles,[2] the Global Task Team Recommendations,[3] and the Paris Declaration.[4] At country level, the AIDS response is often complex and fragmented. Without a clearer focus on harmonising the disparate players and resources, and aligning these behind the single national response, simply contracting out the NAC functions will not address this fragmentation, and will impede our aspiration to most effectively scale up towards universal access.

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## Russia, the G8, and HIV

Although it is true that Russia's HIV epidemic is moving into the general population (May 27, p 1703),[1] Russian reluctance to address issues related to injection drug use will probably stymie efforts to achieve either effective HIV prevention or the universal access to HIV medications promised by 2008. Although the Russian government has increased its support for sterile syringe programmes, coverage still falls far below what is needed. Medications that block craving for illicit opiates such as methadone and buprenorphine, proven to reduce HIV risk behaviours and improve adherence to HIV medications, remain unavailable. And vertical systems of care and provider prejudice mean that injecting drug users—the overwhelming majority of Russians living with HIV—are shunted from one clinic to another.

Even the generalisation of the epidemic is a mark of the reluctance to provide services to drug users and their families, since sexual health programmes that recognise the realities of drug users' lives have been lacking.

President Putin's new willingness to engage the HIV issue is most welcome. But the Russian government and international actors such as the Global Fund will have to work to ensure that this translates into services for injecting drug users, rather than rhetoric that encourages G8 members without improving the lot of most Russians with HIV.

The International Harm Development Program directly funds harm reduction programmes in the former Soviet Union.

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1 The Lancet. Russia, the G8, and HIV. *Lancet* 2006; **367:** 1703.