Punishing Success?
Early Signs of a Retreat from ART

Perspectives from the Field & Current Policy Debates

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MEDECINS SANS FRONTIERES
DOCTORS WITHOUT BORDERS

- International medical humanitarian organisation, founded in 1971
- Emergency medical care in response to armed conflicts, natural and man-made disasters, social exclusion, epidemics
- Field operations in 60+ countries
  - MSF provides ART for +/- 140,000 people in 30 countries
- Awarded 1999 Nobel Peace Prize
- Launch of Campaign for Access to Essential Medicines

Lesotho context

COUNTRY
- HIV prevalence: 23.2% HIV prevalence (3rd highest)
- Life expectancy: 39 years
- Death rate *exceeds* birth rate (recent DHS)
- Catastrophic HR situation
  - Only 6 health centres have full staff complemen
  - 20.9 health workers per 1,000 people in need of ART (Malawi = 44.6)

SCOTT HOSPITAL HEALTH SERVICE AREA
- Population: 220,000
  - 900+ villages
- Geography: remote, mountainous
- Health facilities:
  - 102-bed district hospital
  - 14 rural health centres
- 35,000 PLWHA
  - 10,000 in need of ART (new criteria)
- TB/HIV co-infection rate: >90%

> 5000 people started on ART at 14 health centres and 1 district hospital
((80% AT HEALTH CENTRES))
Enrolled in the programme pre-ART and ART care > 15,000

Outline

- Taking stock
- ART impact
- Early signs of ART retreat
  - Global health actors (GHAs)
  - Countries
- Impact of retreat
- Implications for NGOs
- Conclusion

MEDECINS SANS FRONTIERES
DOCTORS WITHOUT BORDERS

TAKING STOCK

1

Tangible but fragile gains

- Growing scientific knowledge base
- 4 million people alive on ARVs
- Significant reductions in HIV-related mortality
  - 18% decline in annual HIV-related mortality since 2004 in Sub-Saharan Africa
- Reduction in HIV incidence
  - 15% decrease in sub-Saharan Africa => 400,000 fewer infections in 2008

Source: UNAIDS/WHO, 2009; MSF, 2009

ART coverage impact: **strengthening health**

Risk of "**punishing success**" just when we are starting to see **population-level impact** in pockets of high ART coverage

- Reduced overall mortality
- Reduced AIDS incidence
- Reduced TB disease incidence
- Reduced new HIV infections
- Reduced maternal mortality
- Reduced <5 child mortality
- Reduced STI incidence

– Also: evidence of reduction of malaria incidence & progression of HEP-C among pts on ART

… are we moving from "TREAT THE PEOPLE" to "COVER THE COMMUNITY"?

Backlash: a perfect storm

- Financial
  - Costs of the AIDS treatment timebomb
  - "Ballooning entitlement burden" of ART, the treatment mortgage
  - Fears about sustainability
  - Cost effectiveness analysis: where to put limited resources
- Ideological
- Political
  - Northern
  - Southern: If UK wants to hear that MCH is neglected, okay!
- Operational

ONGOING EMERGENCY

2

Global burden

"If we agree to surrender the exceptionality of AIDS, we will come to regret our decision millions of deaths later." (Piot)

- Leading cause of death globally among adults age 15-59 years (WHO, 2006; Piot, 2006)
- Leading **cause of death globally among women of child-bearing age** (WHO, 2009; Ribeiro *et al.*, 2008)
- In the ten highest HIV prevalence countries, AIDS is the leading cause of death (UNAIDS 2009)
  - AIDS is responsible for more than 50% of deaths in the top 6 high burden countries
  - 80% of all deaths in Botswana
  - Two-thirds of all deaths in Lesotho, Swaziland, and Zimbabwe
- For children under the age of 5, AIDS is the lead cause of death in the top 6 burden countries

SIGNS OF ART RETREAT: GLOBAL HEALTH ACTORS

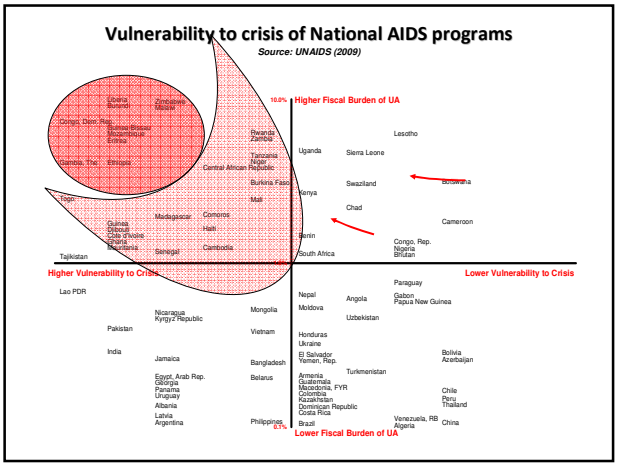
3

Signs of retreat: global health actors

- GFATM
  - Donors on the Board call for change in strategic architecture
    - Creative rationing: efficiency cuts, prioritization, capping, eligibility
  - The best scenario has 34% of UA by 2015, who will pick up the rest
    - Expected to absorb costs but huge problems from other GHAs
  - Replenishment conference
  - Pressure (internal and external) to expand mandate
    - But what of the catalytic/incentivising effect?
- PEPFAR
  - Flatfunded for FY09, FY10, FY11 up to Congress now
  - See role as catalytic but now has huge cohort of ART patients to hand over (the balloon)
  - Country ownership=>programmatic costs
  - Only a handful of countries allowed to scale-up in 2010
- Fewer donors supporting recurrent costs at country level
  - Mainstreaming creative wrap-around, way not to pay for (expensive) comprehenisve approach that includes ART
- Funding for the GF
  - SDC funding needs to more than triple its contribution– USD 20 m is a floor
  - Regular & predictable funding good, but not at the price of "sufficient" levels
  - Operationally, Ambitions and scale-up can't be traded for principle of sustainability

SIGNS OF ART RETREAT: COUNTRY EXAMPLES

4



Consequences: overview

- Budget shortfalls at national level: program cuts, drug shortages
- Less of a buffer/bridge funding to address timing gap between grants, more reliance on single source of funding (DRC, Malawi, CAR)
- Rationing of care/program cuts (e.g. Uganda)
  - Clinic waiting lists (Uganda, Zim)
  - Treatment caps/limited slots (Uganda, Zim, DRC)
  - Moratorium/freezes (Uganda, SA, CAR)
  - Policies to keep uptake low
- WHO guidelines not implementable (status quo second-class care)
  - Clinical rationing=antithesis of new initiation recommendations
- Countries exploring user-fees, other cost-sharing strategies
- Overall:
  - **National ARV programs are more vulnerable to disruption**
  - **More volatility with fewer donors**

Consequences on the ground

- Reduction of annual ART coverage targets
- Pushback of target year of universal coverage
- Less or flatfunding of national investment
- Risk to countries otherwise on target to meet UA (Kenya, Malawi)
- Funding ending in 2010 (in some, COS, but not $ for scale-up)
  - Cameroon
  - Angola
  - DRC
  - CAR
- Financial problems (2010-2011, 2011-2012)
  - Nigeria
  - Swaziland
  - Uganda
  - Zambia

As an implementer, what we see

- an increase in hospitalizations
- people presenting to our projects in search of treatment from other areas (where there used to be treatment). These “treatment migrants” are a throw back to 8-9 years ago.
- because of the volatility
  - MSF has had to again provide ARVs, in some places up to 100% of supply
  - MSF taking back cohorts of stable patients
  - ….Change of plans

As an NGO bearing witness, what we say

Only 10 percent of people – 35,000 people – in the DRC who need ARVs have access to them

"The main reason for the low numbers on treatment is lack of funding”

According to MSF's Benazech, some programmes in the capital are no longer accepting new patients for HIV treatment.

"Many patients coming from the government hospital, which has run out of drugs, arrive at the MSF clinic when they are already extremely weak and close to death so their chances of survival are low," she said.

IMPACT of the retreat

5

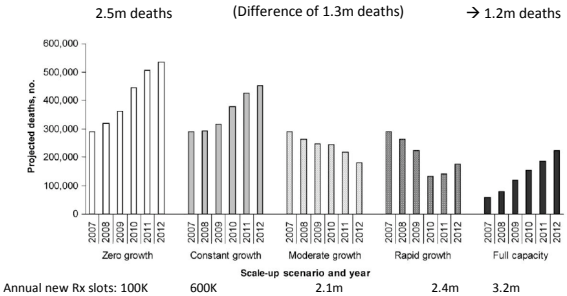
- "Virtually every day, we have to turn away patients who need treatment, including breast-feeding women," said Dr. Peter Mugyenyi, a prominent AIDS specialist in Uganda. "We have to tell them 'There is a freeze.' ”

- US seeks to rein in AIDS program, Boston Globe, 11 April 2010

Survival is linked to timely access, continuity of care, and pace of scale-up

- We don't know yet the full consequences (too early)
  - Betrayal of promise: instead of UA, there are LIMITED SLOTS freed up when pt on ART dies or is lost to follow up
  - Inequity at the household level
- Lessons from South Africa: 3K dead due to 4 month moratorium in Free State province
- Delays in starting ART: disease progression, OIs
- Data from the Western Cape province of South Africa during the pre-ART era show that without ART:
  - 22.2% of patients with stage 4 disease (WHO classification) and a CD4 count of < 200 cells/mm³ would have died within 6 months
- Risk of resistance from treatment interruptions
  - Treatment interuptions related to stockouts
  - Self-rationing of care (or selling/sharing) due to out of pocket costs

Projected number of deaths: linear as opposed to exponential scale-up



Annual new Rx slots: 100K	600K	2.1m	2.4m	3.2m

Source: Walensky 2008

IMPLICATIONS FOR NGOs

6

2010

We know
- it's a special year and an especially dangerous year
- It's likely when the SIZE of the AIDS response will be "fixed" for the coming years….maybe even decade

But it could also be the year when operationally, the package of care is fixed
- …and the costs untennable
- more innovation is still needed

Tension between quantity and quality: Wherever you are now, that's it. ART frozen at hospitals? Or decentralized & integrated before its time.

…the political spotlight dissipating & innovation space shrinking

So, implications for NGOs?

It's the recurrent costs of HIV care that are on the chopping block most clearly.

ARVs
are expensive, more expensive with survival, life-long

DR-TB

That depends…how will you change?

- What will you do in HQs
  - What is the level of commitment you can afford to give & be clear about
  - Will you advocate at national and global levels for the funding needed? (MSF)
    - Will you say that health programmes in endemic countries will not succeed, unless AIDS Rx…
  - Are you reducing your HIV or AIDS treatment-related portfolio?
    - What you lose in public funds can you make up for with private contributions?
  - Will you follow the money?
  - Will you reduce overhead, and put that into programs?
  - Will you budget for buffer stock and bridge funding?
- What will you do in the field
  - For service providers
    - Are you holding back on implementing WHO recommendations (350, TDF)?
    - Will you continue to aim for an impact at community level (mortality & morbidity & incidence)?
    - Will you provide ART for pts coming from outside your catchment area?
    - Will you do what you can to ensure continuity or insist upon sustainability?
    - Principle of austerity: will you reduce cost per person in order to reach more people?
    - What if any support can you provide to DR-TB suspects & patients?

Continued (2)

- For operations researchers
  - Is your OR agenda advocacy-driven, shouldn't it be?
  - What are the pertinent political questions? (Given the rush to mainstream…)
  - How do we define the most affordable and decent package of care that can be integrated and decentralised?
    - For adherence support if we need a Danish psychiatrist we're sunk
  - How can you leverage the HIV "platform" to better increase health for the population?
    - How do you define a patient-centred approach?
      - » What's best for pts? There are efficiencies to be had while meeting pts needs!
    - What indicators are you going to include: HIV incidence, TB, MCH, PCH, etc.?
  - For HSS, how can we we not sacrifice health outcomes for the "brick and mortar"
- Outside of HIV projects
  - Will you advocate for integration of HIV services into "non HIV projects"
  - Can you do PEP for HCWs without PMTCT for pregnant women
  - Can you do testing without treatment? Is the best thing to bury the demand?

Continued (3)

- What will you say
  - To national NGOs, networks of PLWHA, etc.
    - Will you network, share information on the existing and emerging gaps
      - Gaps analyses, risks assessments, environmental analyses, etc.
  - Will you push back on
    - ideology-driven dichotomies that don't reflect the health needs of populations
    - Inequity of treatment access (even at the household level)
  - Will you
    - Re-confirm that HIV is a humanitarian emergency and as such it is **exceptional**?
    - Speak to the fear that if vertical funding (ring-fencing) for ATM is lost, so too will be the incentive and catalyst for ART and DR-TB treatment and programs for at-risk or marginalized populations?
    - Speak to the fear of returning to 2000?
    - Reject the cynical game of pitting a concentrated versus a general epi (and Hi versus Lo prevalence)
    - Speak out about the chance of curbing epidemic (Is it 1996?)
    - Call for a sustainable financing mechanism for health?

Will you today draft a statement. ….and advocate

RESULTS OF MSF EXCERCISE

7

- HIV/AIDS continues to be a major humanitarian crisis, with huge remaining and emerging gaps and challenges
- We call for massive scale-up of HIV treatment, in accordance to WHO recommendations
- This requires large-scale mobilisation of resources as well as new tools & technologies
- Increasing treatment access to high level of coverage in a community can reduce transmission. Therefore funding treatment could lead to reduced overall need.

- To ensure continuity of services we need a mechanism to fund the battle, such as a tax, in order to generate sufficient, regular, and predictable revenue
- To contain the cost explosion and improve care….we need new affordable technologies (POC), patent pool, generic competition, etc.

And what of MSF's role

- Defining its role as an catalyst for change, innovator, and in some contexts, a service provider, MSF commits to
  - Continuing or increasing its level contribution to scale-up of access to treatment in high prevalent settings or in contexts targeting vulnerable/at risk/marginalized groups
  - Reducing mortality as an operational objective (but open to projects to reduce transmission using a bevy of interventions, including ART as prevention)
  - Providing HIV services in its non-vertical programs according to WHO HIV recommendations (TDF, 350, PMTCT, etc.)
  - Integrating TB/HIV and HIV/RH in our projects (as part of a patient-centred approach)

    …. deadline to be determined in the coming weeks

A matter of choice

THE END

THANK YOU

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