

# Political lessons from the global HIV/AIDS response to inform a rapid noncommunicable disease response

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The United Nations high-level meeting on noncommunicable diseases (NCDs) in September 2011 was an important milestone in global health. Discussions were dominated by the relative prioritization of prevention versus treatment for NCDs [1]. Wealthy states are cautious about promising a long-term commitment to NCD care in developing nations because of the costs of interventions and uncertainty about what interventions should be prioritized to yield positive outcomes.

Such debates are reminiscent of those that took place regarding the feasibility of providing widespread access to HIV/AIDS treatment and care in resource-limited settings, despite the evidence that rates of AIDS-related death in Africa were reversing the health gains made in the previous century [2]. Exceptional public health initiatives were developed in order to scale-up HIV/AIDS care in resource-limited settings [3], and these provide several important lessons to help inform the scale-up of NCD care.

The successes of the rapid scale-up of care in Africa could not have occurred without activism and the high-level support of political leaders. Activist groups in both developing and developed countries recognized the need to appeal to political leaders who could commit funding and also encourage commitment from other countries. With financial support from the US Presidency through the President's Emergency Plan for AIDS Relief, multilateral funding via the Global Fund to fight AIDS, tuberculosis, and malaria, and additional support from individual donors, the WHO was able to put forward the

ambitious target of placing 3 million people on antiretroviral therapy (ART) by 2005 [4]. Political support was garnered by the reframing of HIV/AIDS not only as a medical problem but also as public health, economic, and security concern [5]. Political pressure, particularly through the support of generic competition, helped bring the price of ART down from \$10 000 per patient per year to \$60 today. This all occurred against a backdrop of scientific and political cynicism that treatment for AIDS was too complicated, too expensive, and could not be delivered in settings without adequate infrastructure. Country-level political and medical leadership assisted in simplifying the drug regimens and making regionally relevant guidance for algorithms of treatment that respected competing priorities [6].

Current treatment for NCDs is impeded in many settings by the high cost of medicines for cancer, epilepsy, and other NCD medicines [7]. New treatments are on the horizon, but are unlikely to be accessible for populations in developing countries, as NCDs represent a significant part of the global pharmaceutical market. Reminiscent of debates about HIV/AIDS care a decade ago, the most contentious point of negotiation at the UN Summit on NCDs related to public health safeguards to overcome medicine patents [8]. Public advocacy will likely be needed to support access to the most affordable medicines for NCDs and ensure that disadvantaged populations in less-developed countries benefit from medical advances [9]. The potential for a fixed-dose combination (polypill), medication that can reduce cardiovascular disease and cancer risks even in low-risk patients [10,11], may have as

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similar an impact on turning the tide of epidemics as the fixed dose antiretroviral did.

HIV/AIDS programmes have come under recent criticism for diverting resources from the broader goal of health systems strengthening, yet there is little agreement about what indicators represent a strong health system [12]. The fact that the HIV/AIDS response was initially conceived as a vertical programme, with financial and technical resources directed at the specific objective of reducing HIV/AIDS morbidity and mortality, was largely the result of a political choice to frame HIV/AIDS as a disaster requiring an emergency intervention. The successes of the HIV/AIDS health systems approach can be characterized by its focus on supply chain management of drugs and on human resource constraints. Although an integrated response to NCD care is needed to ensure access to care at scale, vertical programmes will likely be initially required in some settings to develop and adapt models of care and generate evidence that NCDs can be managed effectively in under-resourced settings.

Task shifting approaches that delegated specific clinical responsibilities to nonphysician clinicians have been critical to overcoming human resource shortages, and it is notable that, by necessity, these approaches were promoted in policy before being validated in clinical trials [13]. Guidelines were needed to promote the provision of care in the absence of adequate laboratory infrastructure. The delivery of quality care for a disease such as HIV/AIDS in the absence of laboratory infrastructure would have been considered negligent in the west, evidence now indicates that early clinical outcomes were not different between laboratory-guided and clinician-guided therapy [14]. Similarly, many NCDs can be managed with a low level of laboratory infrastructure and although the progressive development of laboratory capacity will better serve patients, this should not be seen as a reason to withhold treatments.

Many African countries today recognize that managing HIV/AIDS as a chronic disease will depend upon developing models of care that go beyond the health system, and several studies have already assessed the feasibility of home and community-based antiretroviral delivery [13]. Such approaches initially borrowed from the concept of patient self-management that is commonly applied to a number of NCDs [15,16].

Treatment for chronic diseases typically requires lifelong access to effective therapy. Few medical conditions have received the meticulous attention to improving adherence and retention in care as HIV/AIDS, yet there is still little agreement about which interventions work best to improve adherence in a given setting [17]. Although some chronic disease treatments may be more forgiving in the requirements for adherence, there will still be a need to define

adherence support interventions, and much can be learnt from the those trials that have been found to have the greatest effect in promoting adherence to antiretrovirals [17].

A recurrent political discussion over the last decade has been how to improve quality of care in an environment of limited funding. Recent trials have demonstrated the benefit of starting ART earlier for both patients and public health, but the translation of this evidence into policy and practice has been hindered by political concerns that, at least in the short term, treating patients earlier will cost more. A similar balance will need to be found to ensure narrow cost-effectiveness arguments do not lead people with NCDs to be subjected to standards of care that would not be accepted in western settings.

The first mistake to be learnt from the last decade of ART scale-up is the assumption that treatment in Africa was too costly and complicated [18,19]. Such views undoubtedly served to delay donor support by several years and resulted in many avoidable deaths. There is also legitimate concern that the initial focus on numbers on treatment led to a delayed appreciation about the substantial attrition and mortality among patients waiting for care, and defaulting from care once treatment was started. NCD programmes should avoid the mistake of focusing only on the patients in the clinics and take care to respond to the needs of the undiagnosed and untreated patients who have yet to receive care. Similarly, efforts to increase numbers on treatment were essential to demonstrate the feasibility of scale-up and engage continued political support, but may have come at the expense of challenging patient groups such as children, adolescents, and the elderly.

A major concern in the HIV/AIDS community is that a growing disinterest in HIV/AIDS is resulting in a default in funding and a subsequent impact on patients' care [20]. Infectious diseases and NCDs can and do occur within the same patient populations and those advocating for increased attention to these health issues should recognize the overlap of diseases, from HIV/AIDS and cancer to malaria and renal failure. High-level political commitment to a particular group of diseases may be relatively straightforward to secure, but the challenge for chronic diseases such as HIV/AIDS and NCDs is to ensure that this political commitment translates into sustainable programmes that will serve patients for longer than the tenure of the politicians who signed the declaration.

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## Conflicts of interest

There are no conflicts of interest.

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