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COMMENTARY

Spreading effective AIDS care in poor countries. A commentary on the Partners-in-Health/Zanmi Lasante experience in Haiti.

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IF in the matter of delivering primary health care for all people everywhere we dealt only with reality, every day would be grim. If, on the other hand, we dealt only with the ideal, we would fail to achieve the target goal. Idealism tempered with reality, or perhaps even better, realism inspired by the ideal, may be the better choice. My comments on the paper by Walton et al. take off from this perspective.

Haiti illustrates well the grim side. The statistics, presented clearly by Dr. Walton and colleagues, are stark and sobering. The depression among health care workers in Cange in the early 1990's, described by Walton et al., when AIDS predominated in the patient population and there were few tools to afford any respite, is understandable; we in the United States felt similarly depressed, as previously healthy young adults presented with advanced AIDS and opportunistic infection for which we could do little too. Health care workers, helpless to help, find it hard to face day after day of bitter outcomes. But, as the experience in Cange demonstrates, it takes relatively little to energize care-providers who actually care, and small success builds the foundation for a better systematic approach. Such was the pathway in Haiti, where the introduction of a feasible directly observed treatment for tuberculosis and AZT to interrupt mother-to-infant transmission of HIV had significant clinical as well as social impact. It is telling that these relatively low cost interventions (but of course still absolutely dependent on major external financing) were accompanied by a substantial increase in pregnant women presenting for counseling and testing,

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and, as described, a reduction in AIDS associated stigma, although I doubt it is all that simple to erase the full and diverse effects of stigmatization.

The leadership of the Partners in Health/Zanmi Lasante program is unique, combining medical and infectious diseases expertise with an anthropology perspective, plus a fair bit of missionary zeal thrown in—the spirit of Schweitzer in Haiti is alive beyond the borders of Deschapelles. Collecting data as services were provided was instrumental in identifying critical gaps and potential interventions, and this was the product of analytic training integrated into the medical training—the habit of asking the how and why and what if questions. However it was the combination of the medical and the social support systems that turned opportunities into remarkable local success.

The question is can this be replicated by others elsewhere? What are the dangers that lurk within less well crafted and executed programs that might be put in place with the funding provided through the Global Fund and other donor initiatives? Which are the most critical elements to focus on when programs are initiated? How can you insure sustainability for the long haul? What questions must be addressed as the programs are rolled out and how can this essential research be imbedded and financed within them? That these are all important elements is supported by the similar level of success of the GHESKIO program in Porte-au-Prince, led by a remarkable Haitian physician, Jean Pape, who, with his colleagues, has implemented and inspired a similar broad based, carefully considered, and expertly executed program in the most urban and impoverished setting in the country. Ultimately it is the clinical responses to treatment and the behavioral changes toward prevention and care seeking that count. Data on the former are, regrettably, not included in the Walton paper.

Recently, one of the central figures in Partners in Health, Dr. Jim Yong Kim, moved to WHO, where he is now responsible for implementing the 3 by 5 program, an ambitious attempt to have 3 million HIV infected patients receiving anti-retroviral therapy by 2005. He will, no doubt, remain mindful of the lessons learned in Haiti. I am struck by the fact that the nature of leadership, characterized by competence, commitment, compassion and charisma is not included among the lessons learned in Haiti. It is necessary to raise this, because in many if not most places attempting to replicate the success of the Haiti programs the critical "C's" will not be there, and may be

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substituted by corruption, control, competition and condescension. Under these circumstances, will compliance with regimens be maintained, will there be continuity of care, and will the clinical response be durable or will drug resistance to the combination HAART regimens available be rapidly selected? How do those responsible for planning and implementing such programs find the balance between insuring that care is available to all in need as quickly as possible to insure equity in access, and insuring that the anti-retrovirals are used wisely to control the emergence of resistance and to provide treatment options in those circumstances where resistance diminishes virological and clinical efficacy. Perhaps the guiding principle ought to be something beyond target numbers such as 3 by 5, for example Safe, Successful and Sustainable treatment or S3 by 5.