The Vancouver Consensus: antiretroviral medicines, medical evidence, and political will

In 1996, the global HIV community gathered in Vancouver, Canada, for the XI International AIDS Conference and shared the clear evidence that triple-combination antiretroviral treatment held the power to stem the tide of deaths from AIDS. The HIV treatment era had begun. As we gathered again in Vancouver in July, 2015, it was clear that a new transformative moment is upon us. The Vancouver Consensus statement,1 which emerged at the recently concluded 8th International AIDS Society Conference on HIV Pathogenesis, Treatment and Prevention (IAS 2015), signals the scientific affirmation that, rather than limiting access to those who are immune compromised, immediate access to antiretroviral medicines holds the power to rapidly advance the fight to end AIDS.

The consensus—signed by more than 500 researchers, clinicians, and civil society experts—is clear: “All people living with HIV must have access to antiretroviral treatment upon diagnosis. Barriers to access in law, policy, stigma and bias must be confronted and dismantled. And as part of a combination prevention effort, PrEP (Pre-Exposure Prophylaxis) must be made available to protect those at high risk of acquiring HIV. The strategic use of ARVs—through treatment and other preventive uses—can save countless millions of lives, reduce new infections, and move us vastly closer to our goal of ending the epidemic. A new era of opportunity against this epidemic has dawned, and we must seize it.”1

The Vancouver Consensus statement comes as a series of major international studies reported results in recent months. Building on knowledge accumulated during the past decade, the Strategic Timing of AntiRetroviral Treatment (START) trial2 released results showing significant health benefits of immediate antiretroviral treatment rather than waiting for immune deterioration. With participants from 35 countries worldwide, including just over half from low-income and middle-income countries, START showed a 57% lower risk of the combined endpoint of serious AIDS-related events, serious non-AIDS-related events, or death among those randomly assigned to immediate antiretroviral treatment.2 The TEMPRANO trial3 showed similar impressive benefits of immediate antiretroviral therapy among African patients, with a 50% lower rate of tuberculosis and a 60% lower rate of bacterial infection, as well as clear benefits of isoniazid preventive therapy. Offering immediate access to antiretroviral medicines is further supported by studies, including the final outcomes of HPTN052, also reported at IAS 2015, which showed that antiretrovirals can prevent transmission from people living with HIV to their uninfected partners. Final results of the HPTN052 study confirmed that the effects are powerful and durable, with a 93% reduction in risk over time through early treatment and no evidence of HIV transmission from people with fully suppressed viral load to their partner.4 Meanwhile, the evidence base is growing that antiretroviral medicines can effectively protect people at risk of infection though prophylactic use and that implementation among key affected populations is feasible.5,6

Around the world today, however, health policy restricts access to antiretroviral medicines to varying degrees. Only ten countries have formally adopted the option for people diagnosed with HIV to start antiretroviral treatment immediately.7 Many countries have not fully implemented WHO recommendations8 to start antiretroviral treatment for people living with HIV at or below CD4 cell counts of 500 cells per μL, several years after their introduction. Some countries
still require people to wait until their CD4 cell count falls as low as 200 cells per μL before becoming “eligible” for antiretroviral treatment. Only three countries (the USA, Thailand, and Malaysia) are currently implementing pre-exposure prophylaxis. It is time to bring policy in line with the best medical evidence.

Barriers to access, however, go beyond CD4 staging policies. The Vancouver Consensus calls “on donors and governments to use existing resources for maximum impact and to mobilize sufficient resources globally to support ARV access for all”. There is an urgent need to identify the resource gap required to ensure access to antiretrovirals for all people living with HIV and secure the funds to implement the UNAIDS 90/90/90 goals in all countries—the UNAIDS goals state that, by 2020, 90% of all people living with HIV will know their HIV status, 90% of all people with diagnosed HIV infection will receive sustained antiretroviral therapy, and 90% of all people receiving antiretroviral therapy will have viral suppression.

There is growing evidence that rapid expansion of coverage in access to antiretrovirals is not only desirable, but also possible. A series of ongoing implementation studies are already showing promising evidence that public health efforts can reach the UNAIDS 90/90/90 goals with high levels of testing, treatment, and adherence. About 19 million people who live with HIV today do not yet know their status, so this evidence is especially important in pressing for a robust testing and counselling agenda if access to antiretrovirals for all is to be realised. Many people living with HIV are not reached by current models of care due to geography or social marginalisation, and so high-quality, community-based strategies for treatment and retention have to move from pilot to scale-up. And ensuring human rights protections will be essential moving forward so that the decision to use antiretrovirals is an individual choice and that all people, irrespective of social or legal status, race, gender, or geography can access effective treatment and prevention. As the Vancouver Consensus also notes, “Knowing medicine cannot work in isolation and ARVs alone cannot end AIDS, a comprehensive response attentive to underserved groups is urgent.”

Medical evidence is unambiguous. At this point, further delays threaten not only millions of lives but also threaten a resurgence of this pandemic. But if we act rapidly, we can drive down HIV incidence, death, and long-term costs. Political will is needed to complete the work of what can be one of the most effective public health interventions in history.

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Global surgery—going beyond the Lancet Commission

In September, 2013, a small group met at the Lancet offices in London to begin planning for a Lancet Commission on Global Surgery. Our aim was to improve access to safe and affordable surgery and anaesthesia care. Our remit, to define the current global surgery landscape, review best practices, and make recommendations. The domains that we were to consider were health systems, workforce, information management, and finance.

In the ensuing 18 months, 25 Commissioners interacted with hundreds of people in 111 countries, held meetings in six continents, and completed dozens of new research studies to start to fill in the gaps in an otherwise evidence-poor field. These studies will be published in The Lancet, The Lancet Global Health, and other journals. The Commission’s findings are presented on April 27, 2015, at the Royal Society of Medicine in London, UK.

Among the five key messages,1 the Commission describes the woeful lack of access to surgery for most of the world’s population (ie, 5 billion people), and the number of individuals who become impoverished seeking and receiving surgical care (81 million). The key messages also describe the number of operations (143 million) needed to alleviate the gaps in access, and, crucially, the benefits to low-income and middle-income countries of remediating the situation (ie, a saving of 2% of gross domestic product). These are powerful messages indeed.

The Commission, combined with the recently published Disease Control Priorities 3 surgery chapter,2 means that, for the first time, global surgery has a strong evidence base to describe the discipline and act as motivation for change. But it will take more than powerful messages and evidence to drive the changes required to help those people who are in need of surgery.

Surgery has an image problem. It is seen as expensive and complex; it comprises multiple treatment modalities for many different diseases, which makes it difficult to define as a cause around which people can easily unite; and it is perceived as peripheral to essential health care by many, from members of the public to policy makers, funders, and governments. Jim Kim and Paul Farmer understood surgery’s image problem when, in 2008, they described surgery as the “neglected stepchild of global health”.3