

# Myths vs. Reality: Distortions About AIDS Drugs & The Developing World

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As the Global AIDS and Health Fund emerges from the vision of advocates worldwide to become a reality, many news articles have appeared focusing on problems associated with providing AIDS drugs to people dying of HIV/AIDS in the developing world. The intent of this document is to place several of the common themes of these articles in their true, undistorted context.

## Infrastructure

- No one disputes that healthcare infrastructure is lacking in many parts of the developing world. These problems should not be minimized, and a broad commitment from world governments to seek solutions is desperately needed.
- As it stands today, vast numbers of people with AIDS are dying in (or within reach of) hospitals and clinics that can dispense prescriptions but lack the medications necessary to save their lives. Infrastructure issues are thus no reason to delay the delivery of treatment, any more than the lack of infrastructure in areas of the US and Western Europe should cause drugs to be withheld in Washington or Paris. Medecins Sans Frontières and Oxfam, both organizations with unquestionable expertise in the field, have repeatedly stated that affordable antiretroviral treatments could save lives immediately.

## Pill Burden & Food Requirements

- "Experts" have been quoted in the press saying that antiretroviral treatment involves "30 to 40 pills a day" when, in fact, none of the first-line treatment combinations recommended in the official US treatment guidelines involve taking this many pills (the minimum is 5; none are more than 15 pills a day). An efficacious combination can typically involve three pills, taken all together twice daily. Recently, both GlaxoSmithKline and CIPLA have taken steps to reduce this burden to just one pill twice daily.
- References to onerous dosing schedules and food and liquid requirements almost exclusively apply to just one protease inhibitor drug, Crixivan. This drug is approved to be taken every 8 hours, on an empty stomach with several glasses of water. In fact, Crixivan is now commonly combined with a low dose of another drug, Norvir, in order to allow twice-daily dosing and circumvent food requirements. Two other antiretroviral drugs, Videx and the rarely used HIVID, must be taken on an empty stomach. No antiretroviral drug has to be taken with milk.

## Adherence & Resistance

- Evidence contradicts the assumption that treatment adherence is unachievable in a developing world setting. Examples come from antiretroviral treatment programs in The Ivory Coast, Brazil and Haiti. A recent plan proposed by Harvard suggests studying adherence support strategies while simultaneously

The Health GAP Coalition is a network of U.S.-based AIDS activists, public health experts, human rights groups, fair trade advocates and individuals dedicated to eliminating barriers to access to affordable life-sustaining medicines for people living with HIV/AIDS in impoverished countries. Access to medication is a fundamental human right that supersedes the commercial interests of the pharmaceutical industry.

delivering antiretroviral treatment in developing countries. This would improve upon the situation in the west, where adherence support programs remain mostly improvised even five years after combination antiretrovirals became available.

- There is no evidence that a "drug resistant supervirus" could develop. Although comparisons with TB are frequently made, TB's genome is made of DNA, making drug-resistance mutations slow to occur but potentially long lived. HIV's genome consists of RNA, meaning mutations can happen rapidly but are much less stable over time. Available evidence (including a recent New England Journal of Medicine study by Steve Deeks et al) demonstrates that multi-drug resistant HIV reproduces less well than non-resistant or "wild-type" virus.

The drug AZT has been available in the US since 1987, but epidemiological evidence shows that less than 10% of new infections involve AZT-resistant HIV. This is despite the fact that for at least eight years AZT was prescribed as a single therapy, and resistance almost inevitably developed. There would thus seem little justification for arguing that the luxury of developing drug resistance should be reserved for people in developed nations.

- Discussion regarding drug resistance rarely acknowledges the ever-expanding genetic diversity of the HIV as it spreads around the world, particularly the world where no treatment exists. A recent study in the Democratic Republic of the Congo was unable to assign 10% of HIV samples to any known clade or subtype of the virus, meaning they contained multiple uncharacterized mutations. Alterations in the behavior of a virus, including altered virulence, are a known risk under these circumstances. Treating HIV and preventing new infections are the best ways of reducing this risk.

## **Prevention**

- Treatment and prevention go hand in hand. The availability of treatment motivates individuals to be tested, whereas stigmatization and certain death discourage people from being informed about HIV status.

- Even in the US, CDC researchers documented a significant increase in the number of people getting tested for HIV over the period 1994 to 1997, the time effective treatments became available and widely publicized due to the Vancouver AIDS conference in 1996.

- Treatment will augment, not replace, the prevention efforts already in place. In many areas, programs currently exist that provide prevention education and palliative care for those with AIDS and HIV infection. Treatment options will greatly expand the credibility and capacity of such programs within their communities.

- Treatment prevents the creation of more orphans. As the world population of children orphaned by AIDS moves into the tens of millions, it is imperative that treatment become rapidly available to infected parents and adult caretakers to stem this massively growing tragedy.

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