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Flat-line funding for PEPFAR: a recipe for chaos

The printed journal includes an image merely for illustration

iStock Photo

I was euphoric when I arrived home in July, 2008, after watching President Bush sign PEPFAR reauthorisation into law, which promised much-needed new resources to help countries such as Uganda transition our emergency HIV response into sustainable programmes under our leadership.

1 year on, there are no additional funds and my euphoria has been replaced by deep concern, especially after a recent trip to Washington, DC, on which I heard many of the same concerns as those voiced in Todd Zwillich's World Report (April 18, p 1325).[1]

The global financial crisis cannot justify a return to the bleak pre-PEPFAR days when limited drug supplies forced us into the agonising position of having to make a choice that only God should make: to choose which desperately ill patients live and which ones die. Already, funding constraints are forcing health clinics to stop enrolling new patients in antiretroviral treatment. After urging people to get tested and enter care, we now have to tell them treatment is not available. We created hope and now we are returning to the days when one member of a family can get treatment and others cannot. This is a recipe for chaos. Patients could start to share their drugs or decrease their doses, leading to drug-resistant strains of HIV and rising death rates.

We cannot risk reversing our progress to date. It is urgent that the US Congress and President Obama deliver on their promise to fully fund the programme in 2010 and beyond.

I am the Executive Director of Uganda's Joint Clinical Research Centre and an adviser to US-based Physicians for Human Rights.

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Multidrug-resistant tuberculosis and quality-assured medicines

In their recommendations to reduce the health threat of multidrug-resistant tuberculosis, Abigail Wright and colleagues (May 30, p 1861)[1] do not mention the role of substandard medicines in drug resistance.

Several studies have reported anti-tuberculosis drugs with insufficient, excess, or incorrect active ingredients; contamination; or poor bioavailability.[2–4] Medicines of substandard quality have serious clinical and public health consequences, including prolonged illness and excess mortality. Underdosing or lower availability of active ingredients, particularly for combination therapies, contributes to drug resistance or to treatment failure despite full patient adherence.

Strong regulatory capacity to implement standards and best practices, including good manufacturing practices, properly documented product development reviewed by qualified assessors, and quality-control surveillance can prevent poor quality medicines from reaching patients. Such comprehensive strategies were endorsed in WHO's 2009 Beijing Call for Action—including the commitment to buy quality-assured medicines and to enforce stringent regulatory standards.[5]

We declare that we have no conflicts of interest.

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Department of Error

Hu S, Tang S, Liu Y, Zhao Y, Escobar M-L, de Ferranti D. Reform of how health care is paid for in China: challenges and opportunities. Lancet *2008;* **372:** *1846–53*—In this Series paper (Nov 22), the source for figure 2 on page 1847 was incorrect and should be: "Wagstaff A, Lindelow M. Health Reform in China: Where Next? In Lou J, Wang S, eds. Public Finance in China: Reform and Growth for a Harmonious Society. Washington, DC: World Bank, 2008." In the panel on page 1848, the amount that central and local governments contribute to medical insurance should be 80 Renmibi. On the same page, the government Ministry leading urban insurance programmes should be the Ministry of Labour and Social Security. The Acknowledgments section should have included: "We acknowledge the seminal research by Adam Wagstaff and Magnus Lindelow on China health policy issues, and have drawn heavily on it." Finally, the journal title in reference 3 should be "*Chin Health Econ*".