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IMPROVING ACCESS TO CARE AND TREATMENT FOR HIV/AIDS IN THE AFRICAN REGION: THE 3 BY 5 INITIATIVE AND BEYOND

Report of the Regional Director

EXECUTIVE SUMMARY

1. HIV/AIDS is the leading cause of morbidity and mortality in the African Region. About 2.3 million people died of AIDS in the Region in 2003, mainly due to lack of access to antiretroviral therapy (ART). Member States have responded to the need for care and treatment by providing services for the management of opportunistic infections, counselling, testing, palliative care and ART. Despite some progress, the coverage of these services is very low: only 2.3% of those in need have access to ART.

2. The main impediments to comprehensive care and treatment have been inadequacies in funding, human resources, medicines and diagnostic technologies. Despite these constraints, countries and international partners have renewed their determination to expand access to HIV/AIDS care and treatment.

3. In December 2003, the WHO launched an initiative to place 3 million people on ART by the end of 2005, The 3 by 5 Initiative. The Regional Office for Africa aims to prolong the lives of people living with HIV/AIDS (PLWHA) by providing guidance on implementing The 3 by 5 Initiative. Accelerated action is needed for advocacy, strengthening of health systems, community mobilization, decentralization, integration and fostering partnerships.

4. Countries will need to develop or update national care plans and establish national care teams; adopt simplified approaches to diagnosis, treatment and follow-up or monitoring; train health care workers; expand access to testing and counselling; increase treatment literacy; and support compliance. They should take action to lower the costs of medicines and diagnostics as well as provide care and treatment for health care workers. Implementing these interventions for care and treatment should not detract from prevention as the most important, key response to HIV/AIDS.

5. The implementation of the strategies and interventions discussed in this document will significantly contribute to improving access to care and treatment for HIV/AIDS in the African Region. Other significant opportunities are offered by the Global Fund to Fight AIDS, Tuberculosis and Malaria; the Multi-country AIDS Programme; the United States President's Emergency Plan for AIDS Relief and the determined actions of PLWHAs.

6. The Regional Committee is requested to review and adopt these orientations for improving access to care and treatment for HIV/AIDS in the African Region.

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INTRODUCTION

1. Human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS) is the greatest health crisis the world is facing today, thwarting development and jeopardizing national security in developing countries through the premature death of millions of adults in their economically productive years. In sub-Saharan Africa, 2.3 million lives were lost to AIDS in 2003, including over 500,000 children under the age of 5 years; an estimated 26.6 million people are currently infected with HIV.[1] The majority of deaths now occur due to lack of access to antiretroviral therapy (ART).

2. Comprehensive care for people living with HIV/AIDS (PLWHA) involves a number of important components. Interventions include counselling and testing; the management of tuberculosis and other opportunistic infections; nutritional care; provision of antiretroviral drugs (ARV); social, spiritual, psychological and palliative care. ART is essential in the response to the morbidity and mortality caused by HIV/AIDS and is critical for prolonging life.

3. Provision of care and treatment in most African countries has been limited due to the high cost of medicines and diagnostics, inadequate health delivery infrastructure and laboratory facilities, and limited human resources due to brain drain and attrition related to HIV/AIDS.

4. The Regional Committee has responded to the HIV/AIDS crisis by passing a number of resolutions[2] on prevention, care and control of HIV in order to stimulate country action. Countries have established programmes for testing and counselling, management of opportunistic infections, community home-based care and ART. However, these efforts have been insufficient for the scale required.

5. In December 2003, WHO launched a programme to place 3 million people on ART by the end of 2005, The 3 by 5 Initiative. This document proposes strategies that will enable Member States in the African Region to improve access to care and treatment for HIV/AIDS, including the provision of ART.

SITUATION ANALYSIS

Magnitude of the problem

6. The epidemic of HIV/AIDS continues its relentless spread in Africa, making the continent the worst affected area globally. At the end of 2003, a total of 40 million people globally were infected with HIV, and 67% of these were living in sub-Saharan Africa. Young people aged 15 to 24 and women are disproportionately affected.[1] Infection rates of young women aged 15 to 19 years are four to six times higher than of men in the same age group; thus specific strategies are required to address discordance in HIV status of young couples. The epidemic has reversed

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[1] UNAIDS/WHO, AIDS epidemic update, December 2003.

[2] HIV/AIDS strategy in the African Region AFR/RC/46/R2(1996); HIV/AIDS strategy in the African Region: A framework for implementation AFR/RC50/11 (2000); Scaling up interventions against HIV/AIDS, tuberculosis and malaria in the WHO African Region AFR/RC53/9 (2003).

decades of gradual gains in life expectancy in Africa which is now projected at a new low of under 46 years during the period 2000–2005.[3]

7. HIV/AIDS has overwhelmed health systems in some countries in the Region. HIV-related bed occupancy is between 30% and 50% of all hospital admissions in severely affected countries.[4] In 2000, 31% of new adult TB cases were HIV-related, while pulmonary TB notification rates have more than doubled during the past decade.[5] AIDS has created more than 11 million African orphans and thus increased dependency ratios.[6]

8. Out of an estimated 4 million people in need of ART in sub-Saharan Africa, only 100 000 have access. Estimated coverage of services for prevention of mother-to-child transmission (PMTCT) and voluntary counselling and testing (VCT) are 1% and 6%, respectively.[7] More than 70% of countries in the Region do not have national ART programmes,[1] and the treatment needs of children are often neglected.

9. Services for the management of opportunistic infections, palliative care, VCT, PMTCT, nutritional care and support, and ART have been offered through the public sector or nongovernmental organizations on a very limited scale and in an uncoordinated way. Community and home-based services have provided nursing and palliative care and have borne the burden of HIV/AIDS care in the Region.[4] On the whole, families and communities are provided with limited testing and treatment services.

10. Rural areas have had inadequate testing and clinical services. Referral links between services are weak. Health care systems have struggled with insufficient staff and inadequate infrastructure and support. Laboratory capacity for diagnosis and monitoring is limited and standardization of procedures and diagnostic kits is inadequate. Although a number of partners are involved in care and treatment, their efforts are poorly coordinated.

11. In the past three years, countries have initiated services for ART, and Member States have negotiated for reduced ARV prices. Although the prices of ARVs have come down to US$ 140 per patient per year in some settings, they are still beyond the budgets of most countries and individuals in the African Region.

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[3] UN, 2001 World population prospects: The 2000 revision, New York, United Nations Population Division, 2001.
[4] UNAIDS, Report on the global HIV/AIDS epidemic, New York, Joint United Nations Programme on HIV/AIDS, 2002.
[5] WHO, HIV/AIDS epidemiological surveillance update for the WHO African Region, Harare, World Health Organization, Regional Office for Africa, 2002.
[6] UNICEF, Africa's orphaned generations, New York, United Nations Children's Fund, 2003.
[7] WHO, The health sector response to HIV/AIDS: Coverage of selected services in 2001, Geneva, World Health Organization, 2002.

Challenges

12. Key challenges that need to be addressed to increase access to treatment and care include the following:

(a) Ensuring that all Member States in the African Region develop and implement comprehensive plans for improving access to care and treatment of HIV/AIDS;

(b) Expanding geographic coverage to improve access to care and treatment of HIV/AIDS by decentralizing management to districts and communities;

(c) Establishing effective mechanisms for mobilizing and coordinating the contributions of various stakeholders;

(d) Strengthening and restoring human capacity in health care systems, including reviewing macroeconomic strategies that severely limit the recruitment of staff, so that sufficient numbers of skilled, motivated and appropriately distributed managers and service providers are available;

(e) Increasing family and community uptake of testing and treatment services in order to reduce stigma and support adherence to long-term treatment;

(f) Reducing the price of quality medicines and diagnostic kits so that they are affordable for delivery throughout public health systems;

(g) Addressing the treatment needs of women, adolescents and children, including the production of paediatric formulations of ARVs by pharmaceutical companies and mobilizing men for their support as national and family decision-makers;

(h) Mobilizing sufficient and sustained financial resources to enable Member States to improve overall access to care and treatment for HIV/AIDS;

(i) Strengthening the monitoring of care programmes, including tracking treatment adherence and minimizing the emergence of resistance to ARVs.

Opportunities

13. In the last five years, there has been increased governmental commitment to the control of HIV infection, including provision of care and treatment. The Abuja, Maseru and Maputo declarations[8] have been important catalysts for action at country level. Subregional groupings such as the Economic and Monetary Community of Central African States, Economic Community of West African States, Inter-Governmental Agency for Development and Southern Africa Development Community have developed plans to increase access to care and treatment.

14. The commitment of the international community is evidenced by the adoption of the millennium development goals and the United Nations General Assembly Special Session on AIDS Declaration and Platform for Action. Increased financial resources are available to

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[8] The Abuja declaration and framework for action to fight HIV/AIDS, TB and other related infectious disease in Africa 2001; Maseru declaration on the fight against HIV/AIDS in the SADC region, July 2003; Maputo declaration on HIV/AIDS, TB and malaria, July 2003.

countries through the Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria; the World Bank Multi-country AIDS Programme and the United States President's Emergency Plan for AIDS Relief. Organizations such as the William J. Clinton Presidential Foundation and Bill and Melinda Gates Foundation are focussing on care and treatment.

15. As a result of advocacy by civil society and negotiations with pharmaceutical companies within the context of the UNAIDS/WHO Accelerated Access Initiative, prices of ARVs have been reduced in the past few years. They are likely to decline even further with the expansion of treatment programmes and the manufacture of cheaper drugs by generic companies.

16. Increasingly well-organized civil societies, particularly networks of PLWHA, are strengthening responses at the community level, notably in social mobilization and treatment compliance.

17. The 3 by 5 Initiative was launched in December 2003. It will mobilize increased resources, accelerate action and partnerships, contribute significantly to improving access to care and treatment in the African Region, and provide an opportunity to improve the quality of health services in the African Region.

OBJECTIVES

18. The general objective is to contribute to restoring the quality and prolonging the lives of PLWHA in the African Region.

Specific objectives to be achieved by the end of 2005 are to:

(a) ensure access to quality and affordable ARV medicines to at least 2 million PLWHA;

(b) ensure access to quality laboratory diagnostic and monitoring (including CD4+) services to at least 50% of PLWHA;

(c) ensure that 60% of health workers and caregivers are adequately trained to provide treatment.

Specific objectives to be achieved by the year 2009 are to:

(a) increase the coverage of HIV/AIDS comprehensive care to 60% of the people in need;

(b) ensure access to quality and affordable ARV medicines to at least 80% of those in need of treatment;

(c) ensure access to quality laboratory diagnostic and monitoring services to at least 70% of PLWHA;

(d) ensure that 80% of health workers and caregivers are adequately trained to provide care and treatment.

GUIDING PRINCIPLES

19. The following principles are proposed to guide policies and strategies for increasing access to care and treatment:

(a) **Working in emergency mode:** There is need to urgently scale up AIDS-related treatment and care. Emergency scaling up of AIDS care and treatment is justified because it is cost-effective, has a synergistic effect on prevention, can sharply reduce HIV/AIDS-related morbidity and mortality, protects human resources and limits negative development effects.

(b) **Country ownership**: Countries should lead the process, and national stakeholders should drive the agenda. International partners should provide support in line with country-defined policies and priorities.

(c) **Sustainability:** The provision of care and treatment is critically dependent on functioning health systems. The 3 by 5 Initiative should lead to strengthened and sustainable health systems with infrastructure, financing and delivery mechanisms capable of providing ART so that ARV becomes part of primary health care. There is need for long-term commitment by governments and partners to ensure that care and treatment programmes are sustained.

(d) **Equity:** Equitable access to care and treatment should be ensured for all. Vulnerable populations should not be marginalized; these include the poor, rural and remote populations, children, adolescents, women, disadvantaged populations, and populations living in emergency and crisis situations. Issues of stigma and discrimination should be addressed.

(e) **Community participation:** It is critical that communities are empowered to play their role in policy setting, programme development, resource mobilization and allocation, implementation and evaluation. Communities are essential in creating awareness and demand for services as well as supporting compliance to treatment. Participatory approaches to programme development and monitoring should be adopted to create an effective interface between communities and the public health system.

(f) **Prevention-care continuum:** Care and treatment programmes should be developed to enhance and complement prevention interventions. The emphasis on care should not detract from the importance of prevention as the most important response to HIV/AIDS.

(g) **Partnership:** Strong and effective partnerships between governments, the private and corporate sectors, NGOs and communities are critical for improving access to care and treatment. PLWHA and their associations are central in these partnerships.

(h) **Reducing HIV-related stigma:** Concerted efforts should be made to reduce the stigma and discrimination related to HIV/AIDS, combining advocacy, community education, legal measures and improved service access. Testing and counselling should be made widely available, and the positive results of treatment should be widely disseminated. Support should be provided for associations of people living with HIV/AIDS to encourage openness and positive living.

STRATEGIES

20. There are various strategies to be put in place to improve access to care and treatment. These strategies concern advocacy, strengthening health systems, decentralization, community mobilization and partnerships.

21. **Advocacy:** Advocacy for improving access to care and treatment will be carried out at international, regional, national and community levels. Efforts will be aimed at ensuring adequate resource mobilization for implementation of activities and provision of affordable, high quality medicines and diagnostics for both adults and children. At country level, advocacy efforts will ensure strong political leadership, the establishment and strengthening of structures and mechanisms to facilitate access, reduce stigma and increase financial allocation to care and treatment programmes.

22. **Strengthening health systems:** Capacity to increase access to care and treatment will depend on strengthened health systems. Health infrastructure, human resources, training, capacity for diagnosis and bio-safety, logistics, supplies management, supervision, planning and evaluation need to be improved. Resources will be needed for adequate staff, equipment and financing. The 3 by 5 Initiative has the potential to strengthen health systems through a number of mechanisms. These include mechanisms to attract resources to the health system, invest in physical infrastructure, develop procurement and distribution systems of generic application, and foster interaction with communities.

23. **Decentralization and integration:** Care and treatment programmes must eventually fit into health sector development policies and strategies. Decentralized and integrated approaches to programme and service delivery will need to be emphasized. This will improve the system and reduce duplication of staff and resources.

24. **Community mobilization:** The role of communities has been central in improving access to care and treatment for HIV/AIDS in many countries. Communities need to be empowered and provided with resources so that they fully participate in the development and delivery of care and treatment services. NGOs and associations of PLWHA need to be involved in ensuring support.

25. **Partnership strengthening and coordination:** Improved access to care and treatment depends on strong partnerships and networks that maximize the contribution of all stakeholders in the country. A mechanism is needed to coordinate all the partners in a country.

26. **Resource mobilization:** Resources should be mobilized to ensure sustainability of treatment access and progress. National governments should improve their financing of health systems and strengthen capacity for delivery. International partners should increase and continue their general budget support and specific funding for treatment programmes. Monitoring of delivery on international commitments to financing HIV/AIDS programmes should be strengthened.

KEY INTERVENTIONS

27. Improving access to HIV/AIDS care and treatment will include interventions which will focus on expanding antiretroviral therapy while consolidating the delivery of a comprehensive care package. Key interventions are discussed below.

28. Countries will need to develop or update national plans for HIV/AIDS care and treatment. These should define targets for coverage and access, including treatment of children, quantify resource gaps and define the roles of relevant Ministry of Health departments and other stakeholders. Such plans are essential for advocacy and mobilization of additional resources. Countries will need to establish or strengthen teams to manage and coordinate these plans.

29. Countries will simplify approaches to testing and counselling, enrolment in antiretroviral therapy and monitoring of treatment, adapting WHO guidelines. They will adopt simple and standardized ART regimens as defined by international technical agencies. This will enable better use of entry points for ART, including TB services, acute and chronic medical care, antenatal clinics, Integrated Management of Childhood Illness, sexually-transmitted infections, VCT, community- and home-based care, and other peripheral services.

30. Member States will establish delivery sites for ART. These may be settings where opportunistic infections are already apparent: TB treatment services, acute medical care wards and home-based care programmes. ART services should be extended to peripheral areas to serve larger numbers of people and to ensure equity. District hospitals and major health centres can act as central facilities for initiating treatment, follow-up and cross-referral of patients and specimens as well as supervision of staff in peripheral centres.

31. Countries will update training to rapidly improve health workers' knowledge and skills. Training institutions will provide pre- and in-service training using standardized training modules. Follow-up support of trainees will be emphasized and funded. At the subregional level, groups of institutions will establish networks for training of trainers.

32. HIV counselling and testing services will have to be expanded at all levels to initiate treatment and support prevention, including the use of lay counsellors. Laboratory services for HIV testing and treatment monitoring will need to be strengthened, especially at district and local level. International technical agencies will need to develop generic policies and guidelines for adoption by countries. These should simplify and shorten counselling in the context of care provision.

33. Community-based programmes for improving knowledge about treatment (treatment literacy and compliance) will be established by Member States. Community-based organizations, especially PLWHA associations, will be supported to play a leading role in these programmes, which have improved treatment adherence and reduced stigma.

34. Countries will improve the estimation and projection of their requirements for medicines and diagnostic kits, and their logistics and management systems. Quality control programmes for

generic and proprietary medicines will be established. Countries will revise their intellectual property legislation and use public health safeguards to improve access to affordable generic drugs. At the subregional level, bulk purchasing, local pharmaceutical production and export to neighbouring countries will be pursued through existing economic organizations.

35. The care and treatment needs of health workers will be incorporated in workplace HIV/AIDS programmes as part of the strategy for sustaining human resources for health. Services will include testing and counselling, post-exposure prophylaxis, treatment, infection control for the protection of both health workers and patients, and peer support.

ROLES AND RESPONSIBILITIES

36. The enormous task of improving access to care and treatment interventions will require concerted efforts from countries, WHO, other United Nations agencies and other international partners.

37. It is the government's role to ensure access to care and treatment. Ministries of health, in collaboration with national AIDS councils, committees and Country Coordinating Mechanisms, have a key leadership and stewardship role in developing plans, mobilizing resources, implementing activities and ensuring the participation of non-health sectors.

38. Emergencies require innovative actions, streamlining or suspending familiar procedures and inventing new ones. Key elements of emergency response include adequate political and financial commitment, high-level national mechanisms for planning and coordination, and ensuring continuous availability of ARV drugs and diagnostics. In addition, governments should ensure accountability in implementation of planned activities and achievement of results. Institutional mechanisms for effective programme implementation and monitoring should be established and activated at district and community levels.

39. WHO will provide support and guidance for development, implementation, monitoring and evaluation of care and treatment plans. WHO will also advocate for more international resources to increase access to care and treatment, facilitate partnerships in the delivery of support to countries, and disseminate lessons learned in implementation.

40. Other partners will participate in the development of national strategic frameworks and implementation plans, monitoring and evaluation; they will provide financial support and technical input based on their comparative advantage. In addition, they will support national capacity building relevant to implementation of care and treatment programmes.

MONITORING AND EVALUATION

41. The monitoring of implementation of this strategy should be undertaken in countries on an ongoing basis, to enable the necessary and timely adjustment of activities. A progress report will be submitted to the Regional Committee every year, with a final review and report after five years. The targets and indicators of the OAU Summits on HIV/AIDS[8] and United Nations

General Assembly Special Session declarations provide a framework for monitoring and evaluation.

CONCLUSION

42. Attention to care and treatment for people with HIV/AIDS has increased significantly in the last few years, with numerous opportunities for increasing access to services. However, mortality due to HIV/AIDS remains high as coverage of services is hampered by weak health systems; insufficient human and financial resources; high cost of medicines and supplies; and insufficient involvement of communities, NGOs and the private sector.

43. The adoption and implementation of effective strategies such as advocacy, capacity strengthening, community mobilization, decentralization, integration and partnership as discussed in this document will enable countries to increase access to care and treatment. Implementation of these interventions will ensure that care and treatment do not detract from prevention as the most important response to HIV/AIDS.

44. The Regional Committee is therefore requested to review and adopt these orientations for improving access to care and treatment for HIV/AIDS in the African Region.