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Agenda item 43
Follow-up to the outcome of the twenty-sixth special session: implementation of the Declaration of Commitment on HIV/AIDS

High-level meeting on HIV/AIDS

Discussion paper for the round table on treatment, care and support to be convened by the World Health Organization and the International Labour Organization

Summary

The present paper is aimed at stimulating discussions in the round table and should be read in conjunction with the forthcoming report of the Secretary-General on progress towards implementation of the Declaration of Commitment on HIV/AIDS.

A summary of the discussions, which are expected to be lively, open and interactive, will be conveyed to the High-level Plenary Meeting of the sixtieth session of the General Assembly in September 2005 so that it may undertake a comprehensive review of the progress made in the fulfilment of the commitments contained in the United Nations Millennium Declaration, including the internationally agreed development goals, and of the progress made in the integrated and coordinated implementation and follow-up to the outcomes of the major United Nations conferences and summits in the economic, social and related fields.

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I. Introduction

1. The 2001 Declaration of Commitment on HIV/AIDS adopted by the General Assembly at its twenty-sixth special session strongly endorsed care, support and treatment for peoples suffering from HIV/AIDS, not just as critical in their own right, but also because they contribute to a comprehensive response to the pandemic. By stimulating demand for voluntary and confidential counselling and testing and improving links between health-care institutions and communities, interventions such as antiretroviral therapy (ART) can in turn help improve access to information, counselling and prevention.

2. In addressing the need for access to treatment, care and support in the Declaration of Commitment, Member States were cognizant that several key barriers were hampering the response of many highly affected countries and that the social, cultural, political and economic determinants of HIV transmission were interdependent. In particular, access to care, treatment and support demand improvement on two fronts. First, human resources and national health and social infrastructures urgently need to be upgraded in order to make the effective delivery of services possible, including complementary services such as home care and nutritional support. Second, continued reductions in the cost of drugs and other key technological inputs are necessary, including paediatric formulations and diagnostic technologies for children younger than 18 months. The lack of affordable pharmaceuticals and effective procurement and supply management infrastructure in many high-burden countries, along with acute shortages of trained staff, have crippled the world's ability to confront HIV/AIDS.

3. In the four years since the special session of the General Assembly on HIV/AIDS, there has been a dramatic change in the global HIV/AIDS landscape. Increased attention to care, treatment and support has been central to this shift. On World AIDS Day 2003, an ambitious target was set to provide antiretroviral therapy to 3 million people living with HIV/AIDS in developing and transitional countries by 2005, representing about half the estimated 6 million people worldwide in urgent need of ART. Building on years of work by Governments, donors, non-governmental organizations (NGOs) and civil society, this target of "3 by 5" aimed to mobilize Governments to redress global inequities in access to life-saving treatment and infuse hope and energy into communities devastated by the epidemic. The target has also enabled better leveraging of the resources of the United Nations system to help countries to scale up comprehensive national treatment, care and support programmes that include treatment and psychosocial and nutritional support.

4. The "3 by 5" effort has been possible because of the commitment of significant new resources to the fight against HIV/AIDS. Many countries have significantly increased their own domestic financial commitments. Internationally, the Global Fund to Fight AIDS, Tuberculosis and Malaria, the United States President's Emergency Plan for AIDS Relief, the World Bank, the Clinton Foundation, Médecins sans frontières and many other organizations have all played important roles in the past four years.

II. Increasing coverage

5. The challenge of providing treatment, care and support in historically underserved communities is daunting, and cannot be minimized. However, in recent months there has been considerable progress, with the number of people on ART in developing and transitional countries increasing between June and December 2004, from 440,000 to an estimated 700,000. This figure represents about 12 per cent of the approximately 5.8 million people currently needing treatment and includes people receiving ART supported by the Global Fund, the United States President's Emergency Plan for AIDS Relief, the World Bank and other partners. It suggests that efforts by the international community and civil society to accelerate the scale-up of treatment programmes are beginning to bear fruit.

6. In sub-Saharan Africa, the number of people on treatment doubled from 150,000 to 310,000 in this six-month period. In Botswana, Kenya, South Africa, Uganda and Zambia, the number of people receiving treatment increased by more than 10,000 per country. The estimated ART coverage in Uganda, Botswana and Namibia now exceeds 25 per cent of all people needing treatment, and 13 countries in the region have exceeded 10 per cent coverage. This region now has well over 700 sites that can deliver ART. Nevertheless, overall coverage in sub-Saharan Africa remains low, at about 8 per cent.

7. In East and South Asia, treatment coverage has also improved: 100,000 people were receiving ART by the end of 2004, twice the number reported six months previously. Thailand's programme has been notably successful, expanding treatment access to all districts, with more than 900 ART facilities and more than 3,000 people starting treatment every month. In Latin America and the Caribbean, Brazil has guaranteed access to ART for its entire population for almost a decade, and nine other countries now have estimated coverage rates exceeding 50 per cent. Progress in Eastern Europe, Central Asia, North Africa and the Middle East has generally been much slower.

III. Partnerships

8. Access to care, treatment and support for people living with HIV/AIDS poses a complex challenge requiring the involvement of not only of Governments and their agencies, but also the private sector: business, labour, corporations, foundations, non-governmental organizations and civil society. In recent months, international mobilization around HIV treatment, care and support has developed into a mature partnership. At least 136 partners are now formally involved as advocates, bilateral donors, advisers, collaborators and providers of funding and technical support and the United Nations system is engaged as never before.

9. Meanwhile, a critical role in treatment, care and support has been played by networks of people living with HIV and by community-based organizations, especially in Africa.[1] They have — almost single-handedly at first — not only forced the issue of treatment onto the international policy agenda, but they have been the first line of response for many communities, offering counselling, support and, in many cases, treatment itself. In Burundi, for example, most people receive antiretroviral drugs through community-based organizations. The efforts of community-based advocacy groups to lobby for access to treatment and bring about

political commitment to providing treatment have inspired similar organizations across Africa, Asia and Eastern Europe. Workplace treatment, care and programmes have also played an important role in complementing NGO and public sector initiatives.

IV. Adherence, treatment success and antiretroviral drug resistance

10. HIV mutates frequently during replication in human cells, and some mutations reduce the effectiveness of HIV drugs. If treatment adherence is poor, resistant HIV strains can emerge and lead to treatment failure. However, if treatment regimens are properly designed and delivered and adherence is high, the emergence of HIV drug resistance will be minimized. There is no evidence to indicate that scaling up ART in developing countries is making the spread of drug-resistant HIV strains more difficult to manage. To date, the resistance to drugs is no higher than that reported by affluent industrialized countries.

11. In Brazil, for example, all AIDS patients have been guaranteed access to antiretroviral therapy. The ART programme's impact on the course of the epidemic has been profound: AIDS-related mortality dropped 50 per cent between 1995 and 1999; overall case incidence declined sharply; and prevalence was cut to half the rate projected in 1992.[2,3] Eight years after the programme was initiated, Brazil has approximately 140,000 people on ART. A cross-sectional study of patients in treatment at public HIV clinics in Rio de Janeiro showed rates of response and adherence to ART comparable to reports from developed countries.[4,5] Primary HIV-1 drug resistance has remained low in Brazil.[6] This experience has been echoed in Côte d'Ivoire and Uganda, where ART was introduced soon after the advent of "triple therapy", through the Accelerating Access Initiative.[7]

12. International efforts are now focusing on working with countries to set up systems for the surveillance and monitoring of HIV drug resistance. Meanwhile, an indispensable role in maintaining levels of adherence to treatment is played by "treatment preparedness" programmes, through which people living with HIV and other community members serve as "treatment supporters" to help educate those about to initiate therapy and to provide support to help patients remain in treatment over the long term. Such initiatives have been demonstrated to increase the rates of treatment success dramatically.[8] The role of adequate diet and nutrition is also increasingly being acknowledged.

V. Current challenges in scaling up HIV treatment, care and support

13. Developing infrastructure and mechanisms at the country level for drug procurement and supply management is currently a key challenge. While countries and programmes are rapidly accumulating first-hand experience in procuring antiretroviral medicines, it is critical that they be supported with a procurement training and support system as well as assistance with forecasting demand and developing systems that can ensure a reliable resupply of facilities. Helping countries to develop efficient procurement and supply management is not only

critical to scaling up ART, but also strengthens capacity to provide treatment for other chronic diseases, such as diabetes and hypertension.

14. As access to HIV care and treatment expands, a continuing, significant constraint is the lack of skilled health-care workers, ranging from specialized physicians to aides and community support workers. As many as 100,000 trained health workers may be needed to realize the "3 by 5" target. Many more will be needed beyond 2005 in order to achieve the objective of universal access to ART. Training and capacity-building programmes now being rolled out provide a technically sound approach to shifting routine clinical management tasks from physicians to nurses and lay providers, including communities working at the front line of the epidemic and people living with HIV/AIDS themselves. Training to provide ART also strengthens the health system, as limited human resources are used optimally and different types of care are integrated. It is also recognized that HIV/AIDS poses specific concerns for health workers and treatment providers.

15. Scaling up treatment and care also requires a dramatic increase in the relatively low percentage of people in high-burden countries who know their HIV serostatus. Testing and counselling are increasingly recognized by national programmes as the gateway to prevention, care, treatment and support interventions, and many countries are now adopting rapid testing technologies and policies that promote the routine offer of HIV testing in a wide range of health services.[9]

16. Despite recent advances, the costs of drugs and diagnostics also remain high, and there is a need to increase the number of producers able to supply quality products. Countries need to make more effective use of the flexibilities available under the Agreement on Trade-Related Aspects of Intellectual Property Rights and the Doha Declaration, while at the same time ensuring that trade agreements and intellectual property regimes at national and regional levels promote the availability of affordable, quality medicines. Global action is required to further lower the price of antiretroviral drugs for both first- and second- line regimens and to develop regimens suitable for children, which are currently up to six times more expensive than adult formulations. New investments are required to develop cheaper technologies to clinically monitor, among other things, viral load and CD4 cell count, and to reduce the prices of existing technologies.

17. Even where HIV/AIDS treatment, care and support are available, social, economic and cultural barriers often limit access for those who need it most, including women, the poor, injecting drug users, men who have sex with men, sex workers and other marginalized groups. These factors include stigma and discrimination against people living with HIV/AIDS and the marginalized social status of women. Efforts to enhance equity of access to treatment and care for these groups need to include setting national targets for access for women and men based on estimated need; monitoring and evaluation of programmes based on data disaggregated by sex and age and identification of who is being reached and who is not; community involvement in programme design and delivery and adjustments in strategies and policies to achieve equitable access, for example by addressing the barriers to access presented by cost-recovery mechanisms.

18. Improving community treatment literacy to create demand for treatment and to support the capacity of families and community members to support those in treatment is essential for long-term sustainability. More effort is also required to

expand community treatment preparedness and education and to increase community and home-based care coverage.

VI. Conclusion

19. **Treating the millions of people living with HIV/AIDS is a humanitarian imperative. As noted in the Declaration of Commitment on HIV/AIDS, prevention and treatment interventions act to reinforce each other and are increasingly seen as integral, rather than discrete, elements of a comprehensive response. As the signatories of the Declaration strive to deliver on their promises, priority concerns must include scaling up HIV counselling and testing, continued efforts to build and optimize human resource capacity for the delivery of treatment, care, support and prevention; improved mechanisms for the procurement and supply of commodities; and community mobilization, monitoring and evaluation. Such approaches will help to ensure that the social, economic and political devastation of HIV/AIDS is finally arrested.**

Notes

[1] Marie de Cenival and Clémence Prunier-Duparge, “Accès commun”, (Paris, SIDACTION, 2004), available from http://www.sidaction.org/accescommun/index_en.php (accessed 31 December 2004).

[2] V. Oliveira-Cruz, J. Kowalski, B. McPake, “The Brazilian HIV/AIDS ‘Success Story’: Can others do it?”, *Tropical medicine and International health*, vol. 9, No. 3 (2004).

[3] J. Rüppel, “Universal and free access to antiretroviral therapy: the experience of Brazil”, unpublished paper, delivered at Access to ART in Developing Countries workshop (24-26 August 2001).

[4] C. B. Hofer, M. Schechter, L. H. Harrison, “Effectiveness of Antiretroviral Therapy Among Patients Who Attend Public HIV Clinics in Rio de Janeiro, Brazil”, *J Acquir Immune Def Syndr*, vol. 36, No. 4 (2004).

[5] Nemes et. al., 2004, AIDS 2004 Suppl. 3.

[6] Marcelo A. Soares, Rodrigo M. Brindeiro, Amilcar Tanuri, “Primary HIV-1 drug resistance in Brazil”, *AIDS*, Vol. 18, Supplement 3 (2004).

[7] *Accelerating Access Initiative, Widening Access to Care and Support for People Living with HIV/AIDS Progress Report*, June 2002, World Health Organization.

[8] S. C. Kalichman, B. Ramachandran, S. Catz, “Adherence to combination antiretroviral therapies in patients of low health literacy”, *J Gen Inter Med*, vol. 4, No. 5 (1999).

[9] UNAIDS/WHO Policy Statement on HIV Testing, http://www.who.int/hiv/pub/vct/en/hivtestingpolicy04.pdf.