



**AFRICASO**



# A COMMITMENT TO ACTION for Expanded Access to HIV/AIDS TREATMENT



INTERNATIONAL HIV TREATMENT  
ACCESS COALITION

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THE REPUBLIC OF UGANDA



Joint United Nations Programme on HIV/AIDS  
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# A COMMITMENT TO ACTION FOR EXPANDED ACCESS TO HIV/AIDS TREATMENT

## HIV/AIDS – THE TOLL IS MOUNTING

Today, 42 million people in the world are living with HIV/AIDS, 95% of them in developing countries<sup>1</sup>. In the countries most severely affected, the epidemic is now beginning to erode key sectors, thwart economic development and jeopardize national security.

Although there is no cure for HIV infection, antiretroviral drugs<sup>2</sup> (ARVs) can dramatically reduce HIV-related morbidity and mortality and improve quality of life. Approximately 800,000 people are taking antiretroviral therapy (ART) worldwide, of whom 500,000 live in high-income countries.

## THE GAP BETWEEN ACCESS AND NEED

It is estimated that between 5 and 6 million adults in developing countries are currently in need of ART. At the end of 2002, only about 300,000 of them are using these drugs. Brazil, an exceptional case due its early initiation of a programme of free and expanded access, accounts for over one-third of those taking ART in resource-limited settings.

These figures represent an increase of 70,000 people on ART in developing countries over the last year. Excluding Brazil, ART use has increased by 50% in all developing countries and by nearly two-thirds in Africa over this period. However, the numbers are very small. Coverage in sub-Saharan Africa, where the burden is greatest, remains unacceptably low, at only 1%, while over 4 million people are in need.

### Coverage of ART in developing countries, December 2002 (adults by region)

Region	Number of people on ART	Estimated need	Coverage
Sub Saharan Africa	50,000	4,100,000	1%
Asia	43,000	1,000,000	4%
North Africa, Middle East	3,000	7,000	29%
Eastern Europe, Central Asia	7,000	80,000	9%
Latin America, Caribbean	196,000	370,000	53%
<b>Total</b>	<b>300,000</b>	<b>5,500,000</b>	<b>5% (Average)</b>

<sup>1</sup> AIDS Epidemic Update, UNAIDS/WHO, December 2002

<sup>2</sup> Antiretroviral refers to a substance that stops or inhibits the replication of a retrovirus such as HIV.

## MODEST GAINS BUT GROWING MOMENTUM

The gains of the last year are modest. Many national programmes are still in the developmental stage and require technical support, increased human resources and lower drug prices in order to be implemented. Some countries are waiting for more advanced programmes to demonstrate results.

However, there is reason for optimism. The international community as a whole is no longer willing to tolerate the situation in which life-saving medicines exist, but millions continue to die every year from HIV/AIDS.

Increasing numbers of people on ART have been accompanied by growing commitment to provide free and expanded access to ARV drugs through the public sector in countries such as Botswana, Costa Rica, Cuba, Nigeria, Senegal and Thailand. Significant drug price reductions have recently been secured in other countries, such as Honduras and Panama, while government subsidies covering at least 50% of drug costs and free laboratory tests are available in Mali. Most governments have now reduced import taxes and duties on HIV-related drugs and commodities, demonstrating their commitment.

In the private sector, businesses and other employers are joining the fight against HIV/AIDS by initiating HIV treatment and care programmes for employees and their family members. Although they cannot substitute for major public programmes, such initiatives can and must play a more important role.

In the last three years, global expenditure on AIDS has increased from just over US\$ 300 million a year to nearly US\$ 3 billion<sup>1</sup>. Establishing and operationalizing the Global Fund to Fight AIDS, TB and Malaria has been a major accomplishment, and the demand to include HIV treatment and care in programmes is increasing. The significant new resources set to flow in the coming year should have a catalytic effect, as national treatment programmes are implemented and their beneficial impact is felt, leading to exponential increases in ART coverage.

Technical hurdles to providing ART in resource-limited settings are gradually being overcome. For example, WHO's guidelines on simplified regimens and laboratory monitoring have greatly reduced the complexity of treatment, and drug quality is being assessed through WHO's programme to prequalify ARV manufacturers.

Meanwhile, even the smallest treatment programmes now under way in Africa, India and the Caribbean are changing the lives of participants for the better. At the same time as they inspire the world, these initiatives offer guidance for scaling up programmes to reach much larger populations.

## CHALLENGES IN DELIVERING HIV/AIDS SERVICES

**A survey conducted by WHO in 70 low-income countries around the world in 2001\* shows that:**

- Half of the countries surveyed have virtually no access to ART
- Half of the countries have virtually no access to services to prevent mother to child transmission of HIV (PMTCT)
- In two thirds of the countries less than a quarter of people have access to voluntary counselling and testing
- Only 1 person in 50 living with advanced HIV infection has access to ART
- Only 1 pregnant woman in 30 has access to PMTCT services

### Opportunities to do better

- Annual global resources for HIV/AIDS have increased from just over US\$ 300 million in 1999 to nearly US\$ 3 billion in 2002
- In sub-Saharan Africa, 40 countries now have national HIV/AIDS strategies, almost three times as many as two years ago
- Since April 2002, 12 ARVs are included in the WHO Model List of Essential Drugs
- The first guidelines on simplified ARV regimens for resource-poor settings were published by WHO in 2002
- Drug prices have fallen on average by 85% in the last two years

\* Coverage of Selected Health Services for HIV/AIDS Prevention and Care in Less Developed Countries in 2001 (WHO, 2002)

<sup>1</sup> UNAIDS PCB (13) / 02.4

# The International HIV Treatment Access Coalition (ITAC)

## Why a coalition ?

With so much of the groundwork done, current opportunities to scale up HIV treatment and care are immense. But there is much that remains unknown, and many challenges that have been identified are beyond the capacity of any one organization to solve. Only a determined effort by the international community to share expertise, coordinate action, and pool resources, will ensure that the current momentum is maintained.

## What is ITAC ?

ITAC is a coalition of partner organizations including people living with HIV/AIDS and their advocates, NGOs, governments, foundations, the private sector, academic and research institutions and international organizations. Their shared goal is expanded access to HIV treatment for all people living with HIV/AIDS who need it, in line with the goals of the Declaration of Commitment of the United Nations General Assembly Special Session on HIV/AIDS.

## What will ITAC do ?

ITAC aims to mobilize and augment its partners' efforts to increase affordability, availability and uptake of HIV treatments. The experiences of pilot HIV treatment programmes offer valuable lessons for scaling up, but need to be widely disseminated. ITAC will add value to current efforts by serving as a platform for exchanging information and enabling knowledge gained from small programmes to be applied to much larger populations. It will also pool and coordinate the technical expertise necessary to make this happen.

The coalition's power lies in the complementary skills and capacities of its partners. Different members will contribute to different elements of the coalition's plan of action.

ITAC's priorities include -

- Sharing information about pilot initiatives so that lessons learnt can be applied to scale up programmes
- Fostering national and international leadership and advocacy, including maintaining pressure for lower drug prices
- Helping to galvanize and coordinate donor action to assist governments embarking upon treatment programmes
- Support the implementation of national HIV treatment programmes, including technical support in planning, procurement of drugs and other commodities, training and human resources
- Monitoring and evaluating programmes: in particular determining the impact of treatment on care and prevention, and how treatment will be integrated into, and boost, an overall comprehensive response to HIV/AIDS in resource limited countries
- Disseminating information about treatment programmes, including training manuals and best practice models
- Promoting an operational research agenda to improve HIV/AIDS service delivery systems (public and private), as part of wider efforts to improve overall systems performance
- Quality control including services, drug manufacturing and provider accreditation.

## Who is involved ?

ITAC partners are organizations which make concrete contributions towards the goals of the coalition. They support partners in resource limited countries with the planning and implementation of HIV treatment programs, and share relevant information on their work with others. ITAC is actively searching for new partners, from both developing and industrialized countries.

The coalition is guided by an interim steering committee composed of representatives of developing countries (Brazil, Uganda, and Thailand), bilateral donors, the Rockefeller Foundation, the Global Business Coalition on HIV/AIDS and NGO's (The Global Network of People Living with HIV/AIDS, African Council of AIDS Service Organizations, The International HIV/AIDS Alliance, The International AIDS Society), and international organizations (the UNAIDS Secretariat, World Bank, and World Health Organization). WHO provides the secretariat for the coalition.

# Why the world must act on access to HIV treatment

## Treatment and prevention together are more effective

In the Declaration of Commitment of the United Nations Special Session on HIV/AIDS<sup>1</sup>, the world clearly acknowledged that both prevention and care must be included as fundamental elements of a stronger overall response to the epidemic. In addressing treatment and care specifically, the Declaration affirms that in the case of HIV/AIDS, public health systems can no longer shirk their responsibility to detect and treat infectious disease. The Declaration represents a unanimous commitment of countries to address the provision of HIV treatment, beginning with the completion of national plans by 2003.

Because antiretroviral drugs are not a cure, scaling up access to ART and HIV/AIDS care needs to be intimately linked to prevention efforts. Treatment will in fact provide new opportunities for prevention, because it will create a larger demand and infrastructure for HIV testing and create settings for counselling of ever greater numbers of infected and non-infected people.

Many countries have allowed prevention programmes to stagnate and have not adequately addressed the needs of people living with HIV/AIDS. In the North, reduced morbidity and mortality among people living with HIV/AIDS brought about by ART is being undermined by stable or even increasing rates of HIV transmission. Developing countries cannot afford to repeat these mistakes.

HIV/AIDS treatment therefore needs to be seen, not as an additional burden, but as a powerful new driver, not only for the response to HIV/AIDS, but for the long-term sustainability of health systems overall.

## ARVs are essential medicines

Essential medicines are those medicines that satisfy priority health care needs. Based on a scientific review of the evidence the WHO Model List of Essential Medicines was updated in 2002 to include twelve ARV drugs. The Model List is used by countries to develop essential drugs lists appropriate to their own needs.

In April 2001 the UN Commission on Human Rights adopted, for the first time, a resolution which recognizes that access to medications in the context of pandemics such as HIV/AIDS is «one fundamental element for achieving progressively the full realization of the right of everyone to the enjoyment of the highest attainable standard of health»<sup>2</sup>.

## Treatment mitigates impact

Industrialized countries have shown the enormous potential for treatment to mitigate the social and economic impact of HIV-related disease. In the developing world, Brazil's unique national treatment programme has brought about a 50% reduction in HIV-related mortality since it began in 1996<sup>3</sup>.

***Does anyone deserve to be sentenced to certain death because she or he cannot access care that costs less than \$ 2 a day? Is anyone's life worth so little? Should any family become destitute as a result? Should children be orphaned?***

***The answers must be no, no, no and no.***

*Dr Gro Harlem Brundtland, Barcelona, July 2002*

<sup>1</sup> Declaration of Commitment on HIV/AIDS, United Nations, June 2001.

<sup>2</sup> Commission on Human Rights resolution 2001/33

<sup>3</sup> National AIDS Drug Policy, Ministry of Health of Brazil. Brasilia 2002

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ART will create similar opportunities for other developing countries. In the countries that have been hardest hit, HIV/AIDS is currently reported to account for 30 to 50% of hospital admissions in some areas<sup>1</sup>. ARVs will significantly reduce the incidence of opportunistic infections and susceptibility to other major diseases, such as tuberculosis<sup>2</sup>. As morbidity and mortality are reduced, significant staff time and resources now devoted to caring for terminally ill patients will be freed up.

HIV/AIDS has also taken a huge toll among health care workers themselves. Treatments are therefore a necessary tool to avert the pernicious 'double hit' of AIDS. The overall effect on health sector morale, costs and capacity will be substantial.

Beyond the health sector, access to treatment will revitalize communities ravaged by disease, prevent households from disintegrating and enable workers to stay productive. Keeping parents alive will secure the education and welfare of future generations. Above all, the effects of treatment will reduce stigma and discrimination, enabling societies to emerge from the shadow of fear and address HIV/AIDS more openly. Many more people living with HIV/AIDS can then be involved as experts, not treated as outcasts.

## NATIONAL PROGRAMMES ENSURE QUALITY

People in resource-limited settings are already taking ARVs. But all too often they are taking one drug instead of three, small doses because they cannot afford the full treatment, splitting drugs with spouses and buying bogus cures.

The result is increased drug resistance and poverty in households, without benefit to individuals or society. Solid national treatment programmes, including appropriate community education and health care worker training, will help prevent these problems.

## INVESTING IN HEALTH PAYS OFF

Over the past few years, a fast-growing body of research is linking investments in health directly to economic growth. It shows that a healthy population is as much a prerequisite for growth as a result of it. The Report of the WHO Commission on Macroeconomics and Health<sup>3</sup> showed that disease is a drain on societies, and states that improving people's health may be the single most important determinant of development in Africa. That is why the response to HIV/AIDS, including HIV treatments, needs to be at the core of public policy, poverty reduction strategies, action for sustainable development and the preservation of human security.

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<sup>1</sup> Report on the Global HIV/AIDS Pandemic, UNAIDS/WHO, July 2002

<sup>2</sup> WHO and UNAIDS figures show that TB accounts for about 11% of AIDS deaths worldwide. In Africa, HIV is the single most important factor determining the increased incidence of TB in the past 10 years. ARVs have been shown to reduce susceptibility to TB disease by 80-90% in both industrialized and developing countries.

<sup>3</sup> World Health Organization, 2001

# THREE million by 2005: CAN it be done?

The Declaration of Commitment of the United Nations General Assembly Special Session on HIV/AIDS sets out actions, goals and targets which all countries have agreed are necessary for a response to HIV/AIDS that matches the scale of the HIV/AIDS epidemic. It includes a commitment to addressing factors affecting the provision of HIV-related drugs, including ARVs<sup>1</sup>.

Building capacity and mobilizing resources on the scale needed to meet global targets can be daunting for countries. However, challenges are not solved by waiting for perfect conditions. The target of three million by the end of 2005 can be met if, for every person on treatment, enough can be done to provide treatment to just one or two more people, every year.

*If we can get cold Coca Cola and beer to every remote corner of Africa, it should not be impossible to do the same with drugs.*

*Dr Joep Lange, President, International AIDS Society, Barcelona, July 2002*

A contemporaneous analysis assessed the feasibility of rapidly scaling up coverage of HIV/AIDS treatment and care to three million people in developing countries by 2005<sup>2</sup>. This target assumes that all the necessary pre-conditions to scaling up are in place, including factors such as political commitment, planning, technical preparedness, infrastructure and financial and human resources.

## Brazil shows the way

Brazil has the most advanced national treatment programme in the developing world. By mid-2002, the programme has 115,000 participants. It is estimated that between 1994-2002, 90,962 deaths have been averted (a 50% drop in mortality). Median survival of participants with AIDS increased from 18 months in 1995 to 58 months after the introduction of ART<sup>1</sup>.

As a result of this programme, there has been a significant decline in the number of hospital admissions. The cost per patient of ART in Brazil has also dropped by 54% since 1997 to US\$ 2,223 per year in 2001<sup>2</sup>. Cost savings in reduced hospital admissions and opportunistic infections are estimated at more than US\$ 1 billion<sup>3</sup>. The programme has also been effective in reducing the rates of TB and other opportunistic infections.

The viability of the Brazilian HIV/AIDS programme, including treatment distribution, owes much to effective social mobilization, including representation of affected communities in government, NGO and other fora.

<sup>1</sup> National AIDS drugs policy, Ministry of Health of Brazil. Brasilia 2002.

<sup>2</sup> [http://www.aids.gov.br/final/biblioteca/folder\\_osc/index\\_ing.htm](http://www.aids.gov.br/final/biblioteca/folder_osc/index_ing.htm)

<sup>3</sup> The Lancet, November 5, 2002

<sup>1</sup> Declaration of Commitment on HIV/AIDS, paragraphs 55-57, United Nations, June 2001.

<sup>2</sup> Resource Needs for HIV/AIDS, Schwartländer B., et al, Science, vol.292 (29 June 2001), pp. 2434-2436

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## RESOURCES ARE INCREASING

It is estimated that the total resources required for scaling up prevention and care to meet the UNGASS goals will grow to US\$ 10.5 billion by 2005 and US\$ 15 billion by 2007<sup>1</sup>.

To date, governments and other donors have pledged more than US\$ 2.1 billion to the Global Fund to Fight AIDS, TB and Malaria, the majority of which will be spent on HIV/AIDS, while the World Bank's Multi-country AIDS Program (MAP) is expected to disburse around US\$ 1 billion for Africa and US\$ 155 million for the Caribbean over the next three to five years. Additional funding to scale up the response, including funding for treatment and care, is becoming available through bilaterals, foundations and other donors.

Although current commitments fall well short of anticipated needs, the international community cannot afford to let these crucial investments fail. It is essential that HIV treatment programmes already under way or ready to be implemented are given the best chance to succeed, through technical support and careful monitoring, so that countries can learn from them and use the results to leverage additional resources.

## Donors moving on HIV treatment and care

In October 2002, representatives of bilateral donor agencies, UNAIDS and WHO met in the Netherlands to hold an informal brainstorming session on «Integrating HAART in care, support and treatment». This informal gathering was the largest donor discussion of expanding access to ART held to date.

Some of the points that arose in the two days of discussion included:

- Past experience shows that new parallel (vertical) systems for ART are not desirable. Existing health systems should be utilised to the maximum.
- Human capacity development will play a crucial role in expanding access to treatment. Donors could enhance their efforts and support in areas of pre-service and in-service training of health staff.
- Private companies are moving into the area of ART for their employees. Donor agencies need to explore innovative ways to work with private sector initiatives.
- It will be important to intensify the exchange of 'lessons learnt'. ITAC is one way to facilitate this exchange of information and a means of bringing together scattered technical expertise.

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<sup>1</sup> Global Resources Needed for Prevention and Care Activities, UNAIDS, October 2002

## MORE NATIONAL PLANS EXIST

In sub-Saharan Africa, 40 countries now have national HIV/AIDS strategies, almost three times as many as two years ago<sup>1</sup>. An analysis of over 90 country HIV/AIDS plans indicates that about 60% of countries have now either incorporated ART into their national plans or have defined specific ART coverage targets<sup>2</sup>.

However, on average, these targets remain cautious, amounting to a combined total in 52 countries of approximately 500,000 people on antiretroviral treatment by 2005, less than 10% of those currently in need. It is highly likely that coverage can be increased well beyond current proposals if other factors are considered, such as the potential for further reductions in drug prices, the likely mitigation of impact on health and other sectors, the

increased technical support being provided by international agencies and the potential of successful programmes to attract additional funding.

Some countries are moving beyond pilot treatment programmes and funding uncertainties to set targets which more accurately match feasibility with need. Thailand is currently providing treatment to 13,000 people with HIV/AIDS, and the government aims to provide universal access by 2005. Uganda has increased coverage from 1000 people two years ago to more than 10,000 currently, and aims to treat 30,000 people by 2005. The Economic Community of West African States (ECOWAS) is aiming to expand coverage to at least 400,000 people in 15 countries by 2005.

## New funding opportunities and World Bank support for ART in the Multi-country AIDS Program (MAP)

The overall objective of the MAP for sub-Saharan Africa and the Caribbean is to dramatically increase access to HIV/AIDS prevention, treatment, care and support programmes in African and Caribbean countries. Available resources in the first stage of funding include US\$ 1 billion for Africa, US\$ 155 million for the Caribbean.

The World Bank has worked closely with African and Caribbean governments, the UNAIDS Secretariat and cosponsors, civil society organizations, and drug companies on expanding access to ART, both through Accelerating Access and other initiatives. Through these partnerships, and drawing on the experiences of Senegal and Barbados, MAP country projects will support two types of activities in ART:

- Strengthening health infrastructure to lay the groundwork for wide-scale administration of ART and other drugs in low-income settings, including the development of guidelines.
- Purchase and distribution of ARV drugs and supplies where they can be administered safely, ethically, effectively, and sustainably.

Each country will be expected to articulate its own approach to ART, with substantial involvement of people living with HIV/AIDS, and to draw up ethical and equitable guidelines for deciding who is to benefit in the initial stages.

MAP support for ART will adhere to the technical conditions established by relevant technical agencies.<sup>1</sup> Initiatives to expand the provision of treatment, care, and support will only be viable when embedded in a sustainable programme that considers financial, human, and logistic resource requirements.

Bank supported projects aim to streamline procedures to enable countries to utilize funds as quickly as possible.

Approved African and Caribbean MAP countries as of November 5, 2002 are Benin, Burkina Faso, Burundi, Cameroon, Cape Verde, Central African Republic, Eritrea, Ethiopia, Gambia, Ghana, Kenya, Madagascar, Nigeria, Senegal, Sierra Leone, Uganda, Barbados, Dominican Republic, Grenada, Jamaica.

<sup>1</sup> See, for example, the extensive technical guidelines set forth in "Safe and Effective Use of Anti-retroviral Treatments in Adults," published by UNAIDS, International AIDS Society and WHO (January 2001).

<sup>1</sup> AIDS Epidemic Update, UNAIDS/WHO, December 2002

<sup>2</sup> Analysis by WHO HIV/AIDS Department, November 2002

## EXISTING INFRASTRUCTURE SHOULD BE USED fully

No health system in the world makes optimal use of existing infrastructure and capacity to deliver treatment for people living with HIV/AIDS. The fact that more capacity is needed cannot be used as an excuse for inaction. Existing health services can be effectively utilized as a basis for the rapid implementation of HIV treatment programmes. This includes using antenatal, child health, STI and TB services as key entry points for HIV treatment and care in addition to traditional hospital services, and ensuring that programmes to prevent mother-to-child transmission address the treatment needs of women and their families as well.

*Treatment is technically feasible in every part of the world. Even the lack of infrastructure is not an excuse – I don't know a single place in the world where the real reason AIDS treatment is unavailable is that the health infrastructure has exhausted its capacity to deliver it.*

*It's not knowledge that's the barrier. It's political will.*

*Dr Peter Piot, Executive Director, Joint United Nations Programme on AIDS, Barcelona, July 2002*

## LOWER DRUG PRICES ARE POSSIBLE

The research and development-based pharmaceutical companies working with the UN on the Accelerating Access Initiative have reduced their prices significantly, beginning in May 2000, with GlaxoSmithKline, Abbott and Merck announcing further reductions in the last two months. Almost simultaneously, generic manufacturers offered significant price reductions in developing country markets. Efforts currently under way with ECOWAS, the Caribbean Community and ARV manufacturers, may facilitate further price reductions.

While these developments are significant, it is clear that, even at close to US\$ 1 per day for a first line regimen, the

cost of ARV drugs is still too high for many developing countries, given current domestic health expenditures. Further substantial reductions are both necessary and possible, and there is reason to believe that prices of under US\$ 0.50 per person per day for first line regimens can be achieved.

It is essential that countries take advantage of the opportunities offered by the Global Fund, the World Bank and other donors to develop and implement treatment programmes now. Increased use of HIV treatments will, of itself, lead to economies of scale and reduced prices, but further advocacy is also necessary to make these drugs more affordable and available.

### Prices of Selected Anti-Retroviral Drugs by Source per patient per year in US Dollars, 2002

ARV	Daily Dosage	Price of R&D drugs for Least Developed Countries	Price of generic versions for Developing Countries (range)
ritonavir (booster)	200 mg	125	N/A
lopinavir /ritonavir	6 caps	500	N/A
nevirapine	400 mg	438	153 – 1920
didanosine	400 mg	310	262 – 1358
stavudine	80 mg	54	51 – 2029
abacavir	600 mg	985	N/A
lamivudine	300 mg	233	102 – 1613
zidovudine	600 mg	438	175 – 1774
zidovudine + lamivudine	900 mg	620	263 – 3110
indinavir	2400 mg	598	701 – 3066
efavirenz	600 mg	350	493 – 2901
saquinavir (hard gel)	2000 mg	857	1752
ZDV + 3TC + ABC	2 pills	1605	N/A
D4T + 3TC + NVP	2 pills	N/A	358
nelfinavir	2500 mg	2361	1533 – 4453

## The business response to HIV/AIDS

Companies with large workforces located in heavily affected regions of the world can make a significant contribution through workplace HIV/AIDS programmes which include prevention, voluntary counselling and testing, treatment and care.

With the support of international initiatives like the Global Business Coalition on HIV/AIDS (GBC), an increasing number of companies are now implementing workplace programmes that include HIV treatment. GBC's database at [www.businessfightsaids.org](http://www.businessfightsaids.org), records baseline information and current practices in workplace HIV programmes.

The mining industry has shown its growing commitment. Debswana, for example, has a long standing project to provide ART to its employees with HIV/AIDS. Anglo American, de Beers and Namdeb all recently announced their intention to provide ART.

In Côte d'Ivoire, a private electricity company, Compagnie Ivoirienne de l'Electricité, started offering ART to all of its employees in 1999. As a result, absenteeism among infected employees decreased by a factor of 10, and the annual costs of low productivity, absenteeism, replacements and funerals decreased from US\$ 1.5 million to US\$ 60,000, for an investment of US\$ 338,000 in 1999 and US\$ 153,000 in the year 2000, respectively<sup>1</sup>.

Heineken has had an AIDS prevention programme in the Central African Republic for 10 years. In 2001 the company started introducing ART in its health service, for employees, their partners and children. At present, the programme is operational in Rwanda and Burundi, and will be extended to all of the company's African locations within a year.

Overall, the response from the business sector is in its early stages, but is gathering pace. Programmes are being developed in partnership with governments, NGOs and international agencies, generally utilizing either in-house medical facilities or contracting services out. Although business cannot replace government leadership, it can make an invaluable contribution in support of government-led programmes. Lower drug prices are therefore important for the long-term viability of private sector schemes, as well.

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<sup>1</sup> The socio-economic impact of HIV/AIDS infection and of investment in antiretroviral therapies on a private company of Abidjan, Cote d'Ivoire. S P Ehoile. Abstract XIV International AIDS Conference Barcelona.

## Substantial ART scale-up will be financed by the Global Fund to fight AIDS, TB and Malaria

The Global Fund is an independent public/private partnership that is poised to become a primary financier of public health interventions in developing countries. Its purpose is to attract significant new resources, then innovatively manage and disburse funds to make a substantial impact in the fight against HIV/AIDS, TB and malaria among communities in greatest need.

The Fund represents a new resolve to support ART scale-up with significant and additional resources. Among the HIV/AIDS proposals approved by the Fund in its first proposal round, 20 countries\* were awarded funds to expand ART which will double the number currently on treatment throughout all developing countries.

The Board of the Fund adopted procurement policies to support the pursuit of these programs by local implementing partners, including NGOs as well as governments. Drugs purchased with Fund resources must be at the lowest possible price and meet quality standards set by WHO, and the sales must be consistent with national law and international agreements.

The flexibility of the Agreement on Trade-Related Aspects of Intellectual Property, as specified in the Doha Declaration, creates opportunities for a competitive market response by both research-based and generic pharmaceutical manufacturers. The Fund is committed to light and innovative disbursement mechanisms as well as a results-driven approach to monitoring & evaluation. The goal is to give countries flexibility in implementation.

The structure of the Fund delegates substantial operational responsibility to international and local partners. The chief task now is to utilize the resources disbursed by the Fund in an effective and efficient manner. To add to the ART grants of Round 1, the Fund will make a new announcement of awards in January 2003, with a third round of proposals to follow later in the Spring.

\* Argentina, Burundi, Cambodia, Chile, Ghana, Haiti, Honduras, Indonesia, Malawi, Moldova, Morocco, Nigeria, Rwanda, South Africa, Senegal, Thailand, Uganda, Ukraine, Zambia and Zimbabwe

# The Way Forward

ITAC will pool and coordinate the resources, knowledge and technical capacity of its partners to accelerate progress on key steps which must now be taken to increase access to HIV/AIDS treatment and care.

## NATIONAL AND INTERNATIONAL LEADERSHIP AND ADVOCACY

### Maintaining the Momentum

Sustained advocacy is needed to maintain the current momentum. Countries rich and poor, need to live up to their international commitments. ITAC partners will create and use all possible fora to mobilize support for expanded access to HIV/AIDS treatment and care. In particular, they will:

- Pursue all possible opportunities to support and foster competition, promote research and development for better drugs and diagnostics, and work with the pharmaceutical industry to make drugs available and affordable to developing country populations
- Work with all stakeholders to ensure that they have access to the information they need to build their expertise in HIV treatment and care and to undertake effective advocacy
- Broker partnerships necessary to expedite the implementation of national treatment programmes

## TECHNICAL SUPPORT AND CAPACITY BUILDING FOR COUNTRIES

### National planning

At the United Nations General Assembly Special Session on HIV/AIDS, countries have committed to the goal of developing national care plans by 2003. ITAC partners will support the development of plans which emphasize the unmet need for HIV treatments and include all sectors of society in their implementation.

As an immediate next step, ITAC partners will support a series of regional consultations on HIV treatment access to be completed by mid-2003, to which Ministers of Health, Heads of State and key policy makers will be invited. The consultations will promote and explore current opportunities to expand access to ART, assess the specific technical assistance governments need to move their programmes forward, and commit more partners to support them.

The consultations will also provide an important opportunity to draw upon the experiences of pilot initiatives now under way and apply their lessons to effectively and rapidly scale up programmes.

### Using all available opportunities

In all health systems there is already some capacity for the rapid implementation of HIV treatment programmes. In providing technical support to countries, ITAC partners will work to ensure that – based on the best evidence – HIV treatments are introduced at the lowest possible level of service delivery. Technical support to and cooperation with TB programmes, maternal health programmes to prevent mother-to-child HIV transmission, sexual and reproductive health services, drug dependence programmes and others, will include assessment of opportunities to provide HIV treatments.

ITAC partners will also actively promote and support the development of comprehensive HIV workplace programmes that incorporate the provision of ARVs by private sector employers in regions heavily affected by HIV/AIDS.

By the end of 2003, best practices in service delivery will be compiled which build on the strengths and innovative capacity of developing countries, including

- The potential for an expanded role for NGOs
- New models of HIV testing and counselling
- Criteria for the accreditation of health facilities.

### Sustainable drug supply

ART is a lifelong commitment and interruptions to supply can endanger life and lead to the development of resistant virus. ITAC members will provide maximum possible support to ongoing efforts to develop efficient procurement mechanisms and supply management programmes.

They will also mobilize technical guidance that national authorities and partners can draw upon to use the flexibility in international trade rules to maximum advantage in expanding access to affordable HIV-related medicines in their countries.

### Human resources

ITAC partners will actively explore ways to build and maintain human resource capacity, including options such as development and maintenance of minimum skill sets, incentive solutions to address staff retention and migration problems, enhancement of the role of NGOs and creation of new provider models.

By early 2003, an international network of institutions will be established to support the development and implementation of training programmes for health care providers.

### Technical resource toolkit

It is important that individual countries do not need to repeatedly 'reinvent the wheel' and that technical

resources and tools produced and used in one setting are made available to others to expedite programme implementation. As programmes are scaled up, such resources will increase in number and will include a wide variety of documentation, tools, models and information in areas such as procurement of commodities, resource mobilization, laboratory infrastructure, budgeting and implementation, human resources, operational and technical guidelines, monitoring and evaluation, clinical tools, recording and reporting systems.

An important element of ITAC's efforts will be to compile and catalogue resources of this kind and make them available in a way which is flexible, accessible and useful for national AIDS programmes. The framework for the different modules of this technical resource 'toolkit' will be developed by mid-2003, drawing upon needs identified through forthcoming regional consultations and other mechanisms. High priority will be given to accessibility of information, both by electronic and other means.

## MONITORING, RESEARCH & EVALUATION

It is essential to learn quickly from success and failure by gathering evidence as part of the scale up process. Coalition partners will work to ensure that programmes are closely monitored and evaluated and use a broad approach to systematically assess the implementation of programmes. This includes:

- Documentation and wide dissemination of programme experiences in order to inform and guide further expansion

- Establishment of a global network to support national efforts in monitoring the emergence of antiretroviral resistance by mid-2003
- Empowering countries by providing guidance on sound and simple monitoring and evaluation of treatment programmes by mid-2003, including a selected set of key indicators to monitor progress
- Development of an operational research agenda and assistance to countries to implement relevant studies throughout 2003
- Promotion of an applied research agenda that focuses on maximizing positive synergy between HIV prevention and care.
- Promotion of R&D agenda for drugs and diagnostics appropriate to developing country settings.

## QUALITY OF SERVICES AND MEDICINES

It is essential that standards are developed and adhered to across the range of activities and services necessary to provide HIV treatment. ITAC partners will ensure that -

- Drug quality is assessed through sustained efforts to assess and prequalify pharmaceutical manufacturers
- Service delivery, including clinical care and laboratory support, is of high quality.

*This is not a time for indecision and prevarication.*

*It is not a time for preoccupation with supposedly insuperable difficulties. Nor is it a time for indefinite plan-making. It is – especially – not a time for grandiose schemes designed to attain perfection. It is unlikely that in our lifetimes we will attain perfection in Africa. Let us attain something less than perfection in the lives of enough Africans to save them from death by AIDS.*

*Justice Edwin Cameron, New York, 2001*

## Civil society: changing lives

Civil society organizations such as non-governmental organizations, community-based organizations and organizations of people living with HIV/AIDS will play critical roles in both creating the context for treatment and the actual implementation of treatment programmes.

In some countries with resource limitations, such as Haiti, NGOs are already at the forefront of providing ART through small pilot schemes. For example the international NGO Partners in Health and its Haitian partner organization, Zamni Lasante, enrolled patients with advanced AIDS in the country's first-ever community-based HIV treatment programme.

For the communities involved, the perception of AIDS has changed and stigma has been reduced. This is reflected in an increasing willingness of patients to discuss diagnosis openly, a 300% increase in demand for HIV testing within the last two years and a reduction in patients' complaints about abuse from their families and community. Treatment has had a favourable impact on staff morale<sup>1</sup>.

A patient in the Haiti programme reported that 'I was a walking skeleton before therapy. I was afraid to go out of my house and no one would buy things from my shop. But now I am fine again... My wife has returned to me and now my children are not ashamed to be seen with me. I can work again'<sup>2</sup>.

The programmes being run by Médecins sans Frontières include more than 2,000 patients on treatment in 10 countries in Africa, the Americas and Asia. The MSF project in Khayelitsha, South Africa provides ART to 300 people. Working in collaboration with the provincial government, it provides support to a government-run programme to prevent mother-to-child transmission of HIV and runs infectious disease clinics within the government primary health care centres. Adherence to this programme has been good and clinical results have been striking<sup>3</sup>.

In India, Y.R.G.CARE, an NGO based in Chennai, is involved in providing ART at cost rate as well as providing AZT to antenatal women through a subsidized pharmacy. Y.R.G.CARE has been providing home-based care and day-care facilities since 1994, and inpatient care since 1995.<sup>4</sup> It has so far trained 202 healthcare workers in 5 states in Southern India and strengthened service delivery by four NGOs<sup>5</sup>. A clinic-based study on survival times and adverse effects experienced by 287 HIV patients receiving ART between 1996 and 2001 showed that ART in patients with advanced disease is feasible and beneficial even in very poor settings.<sup>6</sup>

The knowledge and experience of local organizations will inform the development of national treatment programmes and help sustain long-term community engagement with ART.

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<sup>1</sup> Community-based treatment of advanced HIV disease: introducing DOT-HAART (directly observed therapy with highly active antiretroviral therapy). Paul Farmer et al. Bulletin of the World Health Organization, 2001 79(12)

<sup>2</sup> Introducing ARVs in Resource-poor Settings: Expected and Unexpected Challenges and Consequences. Paul Farmer. <http://www.pih.org/library/essays/IntroducingARVs/plenarytalk.pdf>

<sup>3</sup> [www.msf.org](http://www.msf.org); <http://www.accessmed-msf.org>

<sup>4</sup> <http://www.yrgcare.org/integrated.html>

<sup>5</sup> HIV/AIDS counselling by nurses and healthcare workers-A YRG CARE Experience. SK Satish Kumar et al. Abstracts from XIV International AIDS Conference- July 7-12, 2002.

<sup>6</sup> Source: Abstract 65 poster session: Antiretroviral chemotherapy in resource limited settings; Survival of persons with HIV disease following Antiretroviral therapy in southern India. N Kumarasamy, Y.R.G.CARE. [www.retroconference.org/2002/abstract/13257.htm](http://www.retroconference.org/2002/abstract/13257.htm)

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