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# 3 by 5

## ensuring HIV/AIDS care for all?

actionaid international

**3 BY 5** DISCUSSION PAPER, JUNE 2004

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## Who we are

ActionAid International's vision is a world without poverty in which every person can exercise their right to a life of dignity. We currently work with nine million people in 40 countries across Africa, Asia, Latin America and the Caribbean to obtain this goal.

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# Summary

Unveiled in December 2003, the World Health Organisation's (WHO) ambitious initiative to treat three million people by 2005[1] (hereafter 3 by 5) seeks to provide rapid access to approximately half the estimated six million people who are in dire need of antiretroviral therapy.

ActionAid International believes that HIV/AIDS-related care should be financially, socially and physically accessible to all people in need. We welcome the 3 by 5 initiative as an ambitious plan that emphasises the need to provide treatment to people living with HIV/AIDS in developing countries.

While ActionAid International recognises the importance of antiretroviral (ARV) therapy in responding to HIV/AIDS, our experience at community level, and our consultations with poor people infected or affected by HIV/AIDS, shows that the care requirements of infected persons and their families are multifaceted. Care must encompass nutrition, palliative care including psychosocial support, attention to poverty issues and freedom from discrimination and stigma.

Our experience in developing countries and our analysis of major donors and institutions leads us to believe that there are many hurdles to be surmounted before a good paper strategy like 3 by 5 can be translated into an effective and sustainable system for delivering care to people infected and affected by HIV/AIDS.

This paper addresses these concerns.

**Prevention, care and support:** in the push to provide antiretrovirals, prevention, care and support programmes must not slip down the priority list of the world's governments. ActionAid International calls on developing countries to demonstrate clearly in their 3 by 5 plans how ARV treatment delivery will interface with, and be balanced by, other prevention, care and support initiatives, including the promotion of good nutrition.

**Equity:** initially, the limited supply of ARVs under 3 by 5 will be the focus of a struggle between different interest groups trying to ensure access for their client populations. ActionAid International's past experience would suggest that men, and those that are better off or living in urban areas, will win out over women, children, marginalised groups and those living in rural areas. We call on all involved in developing 3 x 5 plans to ensure equity in access by focusing on the special needs of women, marginalised groups, poor and rural communities. Ideally, such groups should be involved in the design and implementation of care services that will be appropriate to their needs and be located close to where they live.

**Health systems:** ActionAid International welcomes the recent emphasis given by the WHO World Health Assembly to health system strengthening as an essential component in delivery of 3 by 5. In many of the countries most affected by HIV/AIDS health systems are not working, having been undermined by World Bank/IMF structural adjustment programmes as well as attrition caused by HIV/AIDS. The rapid rebuilding of health systems is a basic requirement if 3 by 5 is to succeed. ActionAid International calls on donors to provide increased funding and support and to ensure that large-scale capacity building programmes for health service personnel are instituted without delay.

**The cost of medicines:** the 3 by 5 initiative, or any other treatment programme, will only be cost-effective and successful if the barriers to the export and import of generic medicines are removed. Generic medicines are considerably cheaper than the equivalent patented medicines (US$140 compared to US$462 per patient per year[2]). ActionAid International calls on the industrialised nations to take immediate steps to reform the World Trade Organisation's Trade Related Intellectual Property Rights agreement (TRIPS) and remove similar "TRIPS Plus" clauses from regional and bilateral trade agreements with developing countries.

**Financing 3 by 5:** ActionAid International is concerned that financing for ARV treatment has not been secured in the short or long term. WHO estimates that the immediate provision of technical assistance to implement 3 by 5 will require an additional US$70 million in 2004 and 2005 to funds already pledged. We call on the donor community, as a matter of urgency, to stop vacillating and provide the remainder of the funds needed to ensure WHO technical assistance can proceed without delay.

ActionAid International calls on WHO to develop a long term funding framework that incorporates all existing commitments to treatment and care, both bilateral and multilateral, and clearly highlights resource gaps. We call on all leaders of the industrialised nations to recognise the lifetime commitment that treatment programmes entail by making long-term pledges of commitment.

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[1] World Health Organisation and UNAIDS, Treating 3 million by 2005: Making it happen, The WHO Strategy, 2003, Geneva

[2] BBC News, Indian drugs boss hails AIDS deal, 29 October, 2003, available at http://news.bbc.co.uk/2/hi/south_asia/3220619.stm, and CBS News, Cheap AIDS Drugs on the Way, 6th April 2004, Geneva available at http://www.cbsnews.com/stories/2004/04/06/health/main610436.shtml

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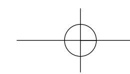






# Introduction

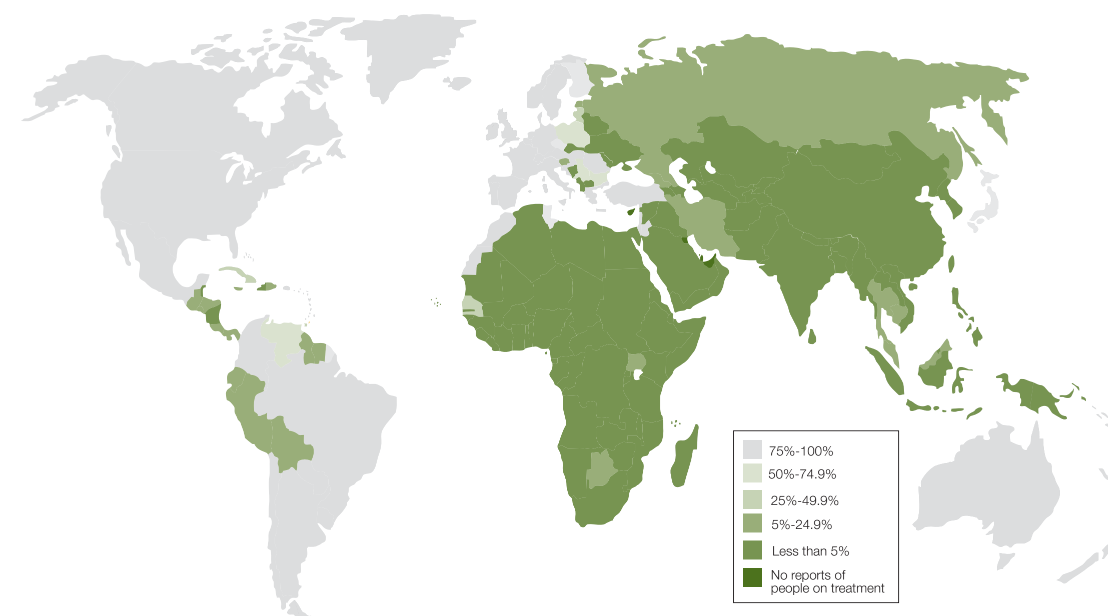
"The 3 by 5 is coming, but not as soon as expected. You learn that people are more generous verbally than when it comes to giving."

Ebrahim Malick Samba, WHO Africa Director (commenting on the 3 by 5 strategy on a visit to Uganda)

It is 23 years since the global HIV/AIDS epidemic was first recognised. Since that time, a large range of new medicines has been developed to provide care for those already living with the virus. The key advance has been the development of life-saving antiretroviral drugs, which have transformed HIV/AIDS from a deadly disease to a manageable, chronic illness.

In industrialised countries, combination antiretroviral drugs have extended and improved the lives of large numbers of people living with HIV/AIDS (PLWHAs). In developing countries, which are home to 95%[3] of PLWHAs, accessing antiretroviral therapy has remained a major challenge. As seen on the map below, in most poor countries, less than 5% of the people who need them are receiving antiretroviral treatment.

**Estimated percentage of adults covered among those in need of antiretroviral treatment. Situation as of November 2003**




Map adapted from WHO and UNAIDS, Treating 3 million by 2005: Making it happen, The WHO Strategy, 2003, Geneva

Unveiled in December 2003, the World Health Organisation's ambitious initiative to treat three million people by 2005[4] (hereafter 3 by 5) seeks to provide rapid access to approximately half the estimated six million people who are in dire need of antiretroviral therapy. WHO describes 3 by 5 as a step towards the ultimate goal of universal access to HIV/AIDS treatment.

The 3 by 5 strategy will achieve its target by working closely with existing HIV/AIDS initiatives. It will seek funding support from the Global Fund to Fight AIDS, Tuberculosis and Malaria and the World Bank Multi–Country HIV/AIDS Programme (MAP) and as well as from developed and developing country governments with whom 3 by 5 partnerships will be established. In addition, WHO will provide technical assistance to developing countries wanting to scale up their treatment programmes.

ActionAid International believes that HIV/AIDS-related care should be financially, socially and physically accessible to all people in need, in line with their rights as set out in the Covenant on Economic Social and Cultural Rights.[5] We welcome the 3 by 5 initiative as an ambitious plan that emphasises the need to provide treatment to people living with HIV/AIDS in developing countries.

While ActionAid International recognises the importance of antiretroviral therapy in responding to HIV/AIDS, our experience at community level, and our consultation with poor people infected or affected by HIV/AIDS, shows that the care requirements of infected persons and their families is multifaceted. Good nutrition, palliative care including psychosocial support, freedom from discrimination and stigma and attention to economic issues are amongst the significant needs that have to be met. Given the structural inequalities they face, special attention is needed to ensure that women and children receive the care they need.

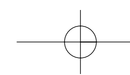
In addition, our experience in developing countries, and our analysis of major donors and institutions, leads us to believe that there are many hurdles to be surmounted before a good paper strategy can be translated into an effective and sustainable system for delivering care to people infected and affected by HIV/AIDS. This will require the full involvement of civil groups, including PLWHA groups, in the design and roll out of HIV/AIDS programmes.

This paper addresses these concerns and calls on all involved in implementing the 3 by 5 target to ensure that these factors form part of national strategies.

[3] World Health Organisation and UNAIDS, Treating 3 million by 2005: Making it happen, The WHO Strategy, 2003, Geneva

[4] World Health Organisation and UNAIDS, 2003, ibid

[5] International Covenant on Economic, Social and Cultural Social Rights, Article 12, 1976, Office of the United Nations Human Rights Commissioner, Geneva



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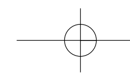




# Treatment, prevention and care

"Rolling out effective HIV/AIDS treatment is the single activity that can most effectively energise and accelerate the uptake and impact of prevention. Under 3 by 5, this will occur as part of a comprehensive strategy linking treatment, prevention, care and full social support for people affected by HIV/AIDS. Such support is critical – both to ensure adherence to antiretroviral therapy and to reinforce prevention."[6]

ActionAid International's analysis suggests that governments in the South may be more comfortable dealing with the treatment component of the pandemic than other aspects, especially if this appears to be the priority of donors and the resources required are provided from external sources. We are concerned that there is a real possibility that prevention may slip down the priority list of world governments and that care and support will be sidelined in the push to provide antiretrovirals.

We would caution against an over-simplistic assumption that ARV treatment will automatically contribute to a successful prevention strategy. While it may be true that being aware that treatment is available will encourage many more people to undergo voluntary testing for HIV, evidence from the UK suggests that ARVs do not automatically lead to transmission rates being reduced. Blower has concluded that increases in high-risk behaviour associated with optimism regarding treatment could negate any beneficial effect of the therapies on transmission.[7] And while the literature is controversial, there is also evidence that attitudinal changes in response to the availability of antiretroviral therapy may have led to increases in high-risk behaviour in industrialised countries.[8]

Prevention depends not only on appropriate and relevant information being available to all, including non-literate populations, but for this to be supported by campaigns to motivate behavioural change, popular leadership and the availability of condoms. Above all, it depends on changing the social structures which drive the epidemic – gender and other inequalities, stigma, silence and poverty.

It is crucial that developing country 3 by 5 plans are holistic in their approach and demonstrate clearly how ARV treatment delivery will interface with, and be balanced by, other prevention, care and support initiatives, including the promotion of good nutrition as a way of delaying the progress of HIV and a necessary component of ARV treatment.

[6] World Health Organisation and UNAIDS, 2003, ibid

[7] Blower S. Calculating the consequences: HAART and risky sex. AIDS 2001; 15

[8] Van de Ven P, Kippax S, Knox S, Prestage G, Crawford J., HIV treatments: optimism and sexual behaviour among gay men in Sydney and Melbourne. AIDS 1999; 13



# Equity and gender

"WHO, UNAIDS and partners will develop principles and approaches for implementing antiretroviral therapy programmes that: promote gender equality; include children and marginalised groups; maintain explicit promotion of antiretroviral therapy among the poor; and ensure comprehensive, community-driven treatment, care, prevention and support for all affected people."[9]

ActionAid International fully supports an approach to treatment programmes that is rights based, poverty focused and ensures that women and children receive equal treatment. But delivering treatment programmes that are truly equitable will be extremely difficult, not least because supplies of ARVs will be limited, as will be the personnel to provide treatment support.

ActionAid International, in common with other development organisations, has witnessed many forms of bias in previous aid and AIDS initiatives, and we are concerned about the lack of conceptual clarity regarding how the decisions about who will receive treatment will be made as national plans are developed.

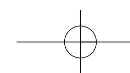
Since ARV supplies will be limited initially, they will be the focus of a struggle between different interest groups trying to ensure access for their client populations. ActionAid International's past experience would suggest that men and those that are better off will win out over women, young people and marginalised groups. In addition, urban dwellers will do better than people living in rural areas, especially remote rural areas. The favoured groups enjoy better access to information, are more aware of their rights and are more capable of advocating them.

Tackling gender inequalities in treatment and ensuring that women receive ARVs is not simply a matter of ensuring that country plans have clear gender balanced targets. Even when medicines are made available to women they may not be able to retain them for their own use, given traditional inequalities between men and women. Sophisticated, locally appropriate strategies are necessary to ensure that gender obstacles to access will be surmounted.

The problem of delivering treatment to rural areas far from major cities must also be addressed directly. Typically, these areas have the weakest health delivery services, not least because of poor infrastructure and funding that make them unattractive postings for health professionals. Country plans must describe clearly how rural access will be assured.

As they develop their plans, ActionAid International calls upon country governments to ensure equity in access by including plans to upgrade their primary health care services in areas where most poor people access care. Effective and well-resourced referral systems must be developed to ensure that poor people can access the drugs close to where they live. Governments should also recognise that psychosocial support at community level is very important in encouraging drug adherence and that developing locally based counsellors to play this role must be part of their plans.

[9] World Health Organisation and UNAIDS, 2003, ibid



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# Strengthening health systems

"Public health systems in countries hardest hit by AIDS are collapsing as increasingly large numbers of people infected with HIV become ill. Even though international support and funding for expanding access to HIV treatment has reached unprecedented levels, substantial resources must be allocated for strengthening public health systems in order to ensure equitable, nationwide, sustainable coverage."[10]

ActionAid International agrees that public health systems in many of the countries hardest hit by HIV/AIDS are failing, but the blame cannot be placed solely on the increase in HIV/AIDS infections. Severe damage to primary healthcare services, and thereby to the general health of populations, had been inflicted by the requirements of structural adjustment programmes long before the impact of the epidemic began to be felt. It is widely acknowledged that the introduction of user-fees deterred the poorest from using services, while the services themselves contracted under pressures to limit public spending.

Whatever the causes, the fact remains that in many of the most affected countries health systems are not working and it is the poorest and those in remote areas who are suffering the consequences. It is hard to see how health systems, rarely implemented in some of the worst affected countries, can be built rapidly without vast inputs of funds from donor nations and capacity building for new personnel on a massive scale.

There is some evidence that the donor community may be tempted to fill perceived gaps by flooding beneficiary countries with trained personnel drawn from their own countries. ActionAid International believes that this would be to the detriment of building long-term capacity. Instead, donors and WHO should consider emerging models of rapid capacity building developed in the South, such as the "preceptorship programme" being piloted by Africa Comprehensive HIV/AIDS Partnership.[11]

Treatment delivery depends on functioning health systems, but health system refurbishment tends to focus on large facilities in the big cities, leaving out the health infrastructure in rural communities where most poor people live. ActionAid International welcomes the recent emphasis that WHO's World Health Assembly has given to health system strengthening as an essential component for delivering 3 by 5, but calls on governments to ensure that rural and urban areas receive equitable treatment. Long-term provision of ARVs can only be achieved through robust and reliable systems and ActionAid International believes that the current emphasis on ARV treatments could be a spur to developing health care systems that would offer lasting benefits to poor communities.

ActionAid International calls on donors to provide increased funding and support and to ensure that large scale capacity building programmes for health service personnel are instituted without delay.

[10] See World Health Organisation, Round Tables: HIV/AIDS, background document for the 57th World Health Assembly 2004, A57/DIV/9, Geneva

[11] http://www.achap.org/



# The cost of medicines

"The viability of antiretroviral therapy programmes and the lives of people living with HIV/AIDS depend on a reliable, efficiently managed supply of quality medicines and diagnostics procured at a sustainable cost. WHO recognises the importance of drug procurement and supply management for scaling up antiretroviral therapy and of the challenges many countries and providers face in this area. For this reason, a key component of the WHO 3 by 5 strategy is the establishment of an AIDS Medicines and Diagnostics Service (AMDS)."[12]

The cost of AIDS medicines remains a major obstacle to achieving the 3 by 5 target. Generic versions of patented medicines, that cost a fraction of the price, are now being produced in countries like Brazil, India and Thailand. The reductions in the price of medicines have opened up the possibility of mass treatment on which the 3 by 5 target is based. (Competition from generic producers as well as amongst themselves has also resulted in the considerable fall in price of patented drugs, but the latter is still prohibitively expensive when compared with average incomes in developing countries.)

WHO is to be applauded for developing the AIDS Medicines and Diagnostics Service (AMDS) and for endorsing the use of fixed-dose combination drugs produced by generic manufacturers. Generic medicines are considerably cheaper than the equivalent patented medicines (US$140 compared to US$462 per patient per year). Furthermore, because the generic versions combine two or three patented medicines into one pill, treatment regimes are made significantly simpler. Simple treatment regimes are essential in promoting adherence, thus reducing the development of drug resistance.

However, WHO's work in this area cannot resolve the problems being caused by the WTO's multilateral agreement on patent rights. The DOHA declaration of 2001 in principle limited the impact of Trade Related Intellectual Property Rights agreement on cost of medicines by reaffirming the right of countries to use compulsory licensing[13] to allow local manufacture of generic medicines to address public health problems. However, this is allowed only for "domestic production and use" and was no help to the poorest countries who lack pharmaceutical manufacturing capacity. In attempting to deal with this shortcoming a waiver has been proposed (which could become an amendment in June 2004 to the WTO's TRIPS agreement) that is supposed to facilitate the import and export of generic drugs. However, the terms of this waiver are extremely complex, with 12 demanding bureaucratic steps to be taken[14] which, if they don't put off importing nations, will certainly deter exporting producers. (For a full discussion of this issue, see accompanying paper.[15])

The 3 by 5 initiative, or any other treatment programme, will only be cost-effective and successful if the barriers to the export and import of generic medicines are removed.

Recognising that these matters can only be resolved by those rich nations who are protecting the interests of their pharmaceutical corporations, both at the WTO and in bilateral and regional trade agreements, ActionAid International calls on the industrialised nations to realise the spirit of the Doha Declaration and take immediate steps to reform the WTO TRIPS agreement and remove "TRIPS Plus" clauses from other trade agreements.

[12] World Health Organisation and UNAIDS, 2003, ibid

[13] The practice of issuing a licence to use the subject matter of a patent without the authorisation of the patent holder

[14] C. Correa, Bridges, Monthly Review, ICTSD, January 2004

[15] Patents, Price and Access to Medicines, ActionAid International, 2004

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# Financing 3 by 5

"Based on current assumptions, the total cost of achieving the target of three million people on ARV treatment by end 2005 is estimated to be at least US$5.5 billion, some of which has already been pledged"[16]

WHO has estimated that to achieve the 3 by 5 target successfully will require a total of US$5.5[17] billion in funding, 60 percent of which represents cost of medicines (ARVs account for 35% of this). This is in addition to current HIV/AIDS spending. The WHO 3 by 5 strategic framework does not address this issue of long term funding; rather major assumptions are made on the goodwill of existing funding streams to provide the needed money.

ActionAid International calls on WHO to develop a long term funding framework, which incorporates all existing funding commitments both bilateral and multilateral with their duration and clearly highlights the gaps in resources needed.

We are concerned that financing for 3 by 5 has not been secured in the short or long term. The Global Fund clearly does not have sufficient contributions to allow it to resource applications from countries that are trying to implement 3 by 5. Nor does the World Bank. So either donors must provide more money in aid or the World Bank, IMF and industrialized nations must consider debt relief or debt cancellation to free up resources for developing countries.

Since ARV treatment is for life and any interruptions may result in rapidly deteriorating health and or drug resistance, it is surprising that WHO and international donors are taking such a relaxed attitude to the issue of financial sustainability of treatment programmes. We call on leaders of all the industrialised nations to recognise since ARV treatment programmes entail a lifetime commitment, it is no longer acceptable that their financial commitments are short term.[18]

WHO estimates that the immediate provision of technical assistance to implement 3 by 5 will require US$200 million in 2004 and 2005. Despite previous commitments to ensure access to medicines, support from G8 countries has been weak. Until recently, the UK was the only G8 country to have pledged funds to 3 by 5 (US$5 million)[19], but in a very welcome move Canada has also pledged US$72 million.[20] This still leaves a funding gap for the programme of some US$ 70 million, despite internal contributions from WHO's central budget and from UNAIDS.

Forty-seven countries have requested the WHO technical assistance, but with funds so short. ActionAid International is concerned that WHO will not be able to support them all. If that happens a transparent process for deciding who should be assisted and who should not will be essential.

Actionaid believes that the donor community as a matter of urgency should fund the WHO technical assistance to strengthen the country health systems.

# Conclusions

The 3 by 5 initiative is warmly welcomed for its recognition that tackling the HIV/AIDS pandemic depends on a comprehensive package of care including antiretroviral treatment. However, there are many challenging obstacles to successful implementation in developing countries. These can only be overcome by a positive and generous approach from donor nations and strong political leadership in affected countries. Most important, however, will be the involvement of poor communities, women, PLWHAs and civil groups, on whose contributions successful delivery will depend.

[16] World Health Organisation and UNAIDs, ibid

[17] http://www.who.int/3by5/publications/documents/en/cost_of_3by5.pdf

[18] For a full discussion of funding issues see, ActionAid International, Commitment to Care? The Role of Donor Countries and Multilateral Institutions in Financing HIV/AIDS Programmes, 2004

[19] HIV Treatment Bulletin, Vol 5 No 3, April 2004, UK

[20] http://www.kaisernetwork.org/daily_reports/rep_index.cfm?DR_ID=23637

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