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HIV/AIDS: Behandlung und Pflege

The 3 by 5 Initiative

Up-scaling access to antiretroviral medicines

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"3 by 5 is a moral-ethical imperative, if we take into account that its achievement is technically feasible." - Providing access to ART to 3 million people living with HIV/AIDS in developing countries by the end of 2005: What are the biggest challenges? What is the role of NGOs and international institutions?

In developing countries, every year three million people die because of our collective incapacity to provide them with the antiretroviral drugs they need to improve their well-being and prolong their lives. To those who have perished without ever being able to feel the hope brought by antiretrovirals, it was as if the billions of dollars spent in finding new and more powerful medicines were spent for nothing.

However, until very recently the majority of the international community didn't think so. For years and years, antiretroviral therapy was believed to be too complicated for developing countries. Resources should be channelled to prevention in the hope that this would turn the tide against the epidemic. The very few countries which dared to care for those infected were deemed to be either foolish or destined to failure.

Yet the results are well known. The spread of AIDS didn't abate. On the contrary, it accelerated. It was only in Barcelona, in July 2002, that a consensus started to emerge about the need to integrate prevention, care, treatment and advocacy of the rights of people living with HIV/AIDS to build an effective response to AIDS.

Fighting against AIDS also involves strengthening prevention and defending the rights of people living with the disease. In both areas much is still to be done, particularly concerning the situation of marginalized populations, such as injecting drug users, men who have sex with men, commercial sex workers and migrants. As such, prevention and human rights are integral elements of the "3 by 5" initiative. Only comprehensive responses are able to control the spread of AIDS. We are working, along with our partners, to realize the targets agreed upon at the Millennium General Assembly and at the Special Session on HIV/AIDS, held roughly two and a half years ago. Now, what we are doing is in fact adding one immense challenge to the UNGASS targets, which is expanding access to antiretroviral treatment to those millions of people in need in developing countries.

However, despite the growing consensus about access to treatment, the situation has improved very little for the millions of people living with AIDS. Only 5% of those who need antiretrovirals are able to access them. This is a global health emergency, as has been declared by WHO and UNAIDS. We simply cannot go on watching millions of people die while we have the technical expertise, the drugs, the political commitment, and unprecedented, yet still insufficient, financial resources to roll out ARV treatment.

ARV roll out has become inevitable. The experiences from several countries, including Senegal, Brazil, Haiti and fourteen other low-income countries where MSF runs ARV treatment sites, point to only one direction: antiretroviral drugs can be successfully provided in resource-poor countries. These convictions are underpinned not by faith or ideology, but by facts. In Brazil, morbidity and mortality have fallen sharply, and the difference between the total costs of its ARV distribution program and the savings from ambulatory care and hospitalizations resulted in net savings of 200 million US$ for the Brazilian Government in five years.

To confront this reality, the Director-General of WHO has committed the entire organization towards achieving an ambitious, but necessary goal: delivering antiretroviral medicines to three million people in developing countries by the end of 2005. Three million is the estimated number of people that could be treated by 2005 if the necessary resources – financial, human and political – were in place. Above all, ”3 by 5” is a moral-ethical imperative, if we take into account that its achievement is technically feasible.

Considerable financial resources have been mobilized to cope with the time that has been lost. There are now at least four and a half billion dollars flowing from or committed by the Global Fund and the World Bank to strengthen the fight against HIV/AIDS worldwide. Although large, such figures still fall far short of what will be needed to face this crisis and may even not translate into results for patients.

Under current funding levels, we estimate that less than a million people will be receiving antiretroviral treatment by the end of 2005. In the context of a global target such as "3 by 5", this is appalling. Poor countries can and should increase their national allocations to AIDS treatment and care, but it is inevitable that developed countries, where the world's wealth is largely concentrated, will need to shoulder the lion's share of this endeavour. They need to considerably increase their contributions to help developing countries cope with an epidemic that threatens their very survival. And they will have to do so either directly, or indirectly, through the multilateral financial institutions they control, such as the World Bank, the International Monetary Fund and the Global Fund. In fact, spending caps imposed by the IMF in the context of structural adjustment programs have to be revisited. Mozambique and Tanzania, for example, have been operating under a hiring freeze in the public sector. Such caps are in direct contraction with the kind of massive human resource capacity building and systemic strengthening that ART scale up will leverage and depend on.

Increased funding will also need to flow to organizations that are working with countries to ensure that these monies are well spent. Such field of activity has a name, and it is called technical assistance. Although it is well known that the current lack of technical capacity in a large number of recipients is constraining the roll out of ARVs, most donors have done very little to attend the appeals of organizations that are providing technical support to countries. Technical assistance has been left severely under-funded, and lip service has been the norm.

The results of such perverse policies are starting to appear, and they take the form of very slow implementation rates, once again penalizing those who are infected and need antiretrovirals.

This state of affairs is threatening to undermine the achievement of the goals contained in the proposals approved by the Global Fund Board, but, above all, may threaten the very viability of the Global Fund structure to remain as one of the largest financiers of the global fight against AIDS, tuberculosis and malaria.

It would be comfortable to think that this is a problem only of Global Fund grants. The reality, however, is that World Bank MAP projects are also facing serious delays. Patients, however, cannot wait. This will not change unless the current structure of international financing for health changes and the institutions mandated to assist recipient countries are finally able to raise the resources necessary to fulfil their duties.

The United Nations system, particularly the World Health Organization and UNAIDS, has a key role to play in unblocking the implementation of Global Fund, World Bank and other resources. However, WHO and UNAIDS are among the institutions that have been most affected by such chronic lack of funding. WHO, for instance, has clear comparative advantages in technical areas which are exactly the ones that continue to pose the greatest obstacles to treatment scale up, such as in monitoring the emergence of resistance to ARV drugs, whose consumption is set to increase ten-fold in the next couple of years; in implementing an iterative operational research agenda that can continuously inform changes and adaptations in strategy to reflect lessons learned; in developing training approaches and materials, and in accrediting training institutions.

WHO is also very careful not to displace, replace or duplicate the technical support being provided by other organizations, and for that reason, maintains an extensive network of in-country partners to help it tailor its support to country needs and match it with other partners' work. As examples of these partnerships we can mention the German GTZ Backup Initiative and the French Initiative ESTHER.

WHO has estimated that 218 million US$ are needed for initial 3 by 5 activities. Besides support from GTZ and Esther, only 5,5 million US$, donated by the United Kingdom, have been made available so far. However, WHO has already received requests for assistance from over 45 countries seeking to scale up their ARV treatment programs. In order to attend such requests in spite of the shortage of funds, more than 30 international staff were re-deployed in the last month, so as to strengthen country level capacity. We all acknowledge, however, that this is not a long term solution. This will only be achieved by revisiting the UN's current funding system, which renders it an impotent executor of a mandate that was, in the very first place, approved by Member States, including the donor community itself.

Despite all financial difficulties, "3 by 5" has mobilized countries and provided the international community with a clear sense of strategic direction regarding antiretroviral treatment. Thus, although it was at first proposed and catalysed by WHO, the warm welcome it received has transformed "3 by 5" into a common goal, a shared vision. The fact that over 45 countries, covering more than 90% of patients in need, have formally declared their commitment to treatment scale up in the context of "3 by 5" is enormously encouraging. This is a consequence not only of strong advocacy, but also demonstrates the consistency of the strategy proposed by WHO.

"3 by 5" was launched by WHO, as the international organization responsible for the health sector response to AIDS, to provide the international community with a clear sense of strategic direction regarding antiretroviral treatment.
Based on the experiences I mentioned before, WHO published a much simplified version of its ARV treatment guidelines, bearing in mind the needs of both countries and end-users. It focuses on basic laboratory exams, simplified treatment schemes – instead of the usual 34 possible schemes, we reduced this number to four – and will rely heavily on clinical parameters for treatment follow-up. Based on simple technical guidelines, we hope to facilitate a massive roll-out of training activities to overcome the lack of human resources that now hampers a drastic ARV scale up.

Considering the facts that effectively delivering antiretrovirals requires high adherence levels and the poor health infrastructure in the majority of developing countries, WHO concluded that the use of fixed-dose combinations (FDC) of these drugs is one of the most adequate ways to overcome this complex and challenging situation. However, other important issues must be further explored: adequate paediatric ARV formulation, simplified laboratory monitoring tests and improvement of adherence strategies.

Such activities will assist countries overcome and fill the "absorptive capacity gap" that has structurally hindered country-level program implementation. The key to break with this circle is not to deny that countries many times face structural capacity constraints, but to understand how antiretroviral treatment can significantly enhance the absorptive capacity of current structures while investments are made into building and creating new, better ones. Sceptics fail to acknowledge that ARV treatment is in itself one of the most efficient mechanisms to increase absorptive capacity in countries. With ARV treatment, doctors and nurses don't simply die; they continue to care for patients, civil servants continue to provide social services, teachers continue to teach, mothers continue to rear their children, communities continue to sustain the social fabric.

"3 by 5" is a framework for collective action to mobilize a new alliance of the caring and committed towards the common goal of promoting access to treatment. It is not a WHO-only project. The key for success rests with enlisting and ensuring proper coordination among the vast array of partners involved in one or another aspect of the fight against AIDS. To tap on the experience of different institutions with ongoing programs of ARV delivery in resource-limited settings, we established a "Partners Group". At the same time, WHO has also established a Community Advisory Group, comprised of 15 to 20 representatives of the various communities – CBOs, FBOs, men who have sex with men, commercial sex workers, incarcerated populations, etc. These are people working on the ground, from both developing and developed countries, whose expertise will help shape the way "3 by 5" is designed and implemented.

Communities will need to step up the intensity and breadth of their activities, both at the local and global levels, to support the roll out of ARVs. At the global level, the advocacy work that has been developed so far will need to be strengthened and revamped to cope with new and emerging matters, such as increased funding for technical providers. The communities have a critical role to play in mobilizing donor support to such activities.

At the local level, communities, specially people living with HIV/AIDS, can and should increase their involvement in the implementation of programs, particularly in adherence groups and treatment follow up. I am specifically thinking of strategies such as those employed in Haiti and Brazil, where people living with AIDS play a fundamental role in maintaining the viability of their ARV distribution program. Besides, the delegation of authority envisioned in "3 by 5" means that community health workers will play a fundamental role to make the scaling up possible, by releasing scarce medical human resources and empowering communities to better and more closely do treatment follow up.

Let's work together to transform this vision into reality.

Some WHO key resources on HIV/AIDS treatment

Treating 3 million by 2005: Making it happen
Treating 3 million people by the end of 2005 will require concerted, sustained action by many partners. To chart the direction and to show what WHO itself will be doing to accelerate action, WHO has developed an initial strategic framework.
http://www.who.int/entity/3by5/publications/documents/isbn9241591129/en

Scaling up antiretroviral therapy in resource-limited settings: Treatment guidelines for a public health approach
The topics addressed in these treatment guidelines include when to start ART, which antiretroviral regimens to start, reasons for changing ART, and what regimens to continue if treatment needs to be changed. It also addresses how treatment should be monitored, with specific reference to the side effects of ART, and makes specific recommendations for certain patient subgroups. (available in English and French)
http://www.who.int/3by5/publications/documents/arv_guidelines/en/
http://www.who.int/hiv/toolkit/arv

World Health Report 2004: "Changing History"
The report chronicles the global spread of HIV/AIDS and details the need for linking prevention, treatment, care and support for people living with the virus. It concludes that coordinated efforts now to control one of the worst global epidemics, could change the course of history.
World Health Report: www.who.int/whr/2004

**Paolo Teixeira, former head of the HIV/AIDS Department, World Health Organisation, Geneva, was represented at the aidsfocus conference by Nasiadet Mason, WHO human rights and advocacy adviser. Contact: www.who.int/hiv/en. The PowerPoint slides of their presentation are available on the conference website. WHO 3 by 5 Initiative: www.3by5.org*

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