

HIV and AIDS treatment and care policy



Cover photo: *Sitting on Mother's Grave*. Three Kenyan orphans sit on the grave of their mother who died the week before. WHO/Andrew Petkun
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by the Rt Hon Hilary Benn MP Secretary of State for International Development

People with HIV and AIDS need good quality treatment and care that is available, accessible and affordable worldwide. This is essential to tackle HIV and AIDS, improve people's lives, and protect the significant development gains of the last 20 years.

Only 400,000 of the 6 million people in the developing world who need treatment with antiretroviral therapy (ART) are able to receive it. Of these, few will receive full treatment and care.

We fully support the WHO and UNAIDS '3 by 5' framework and its target to get 3 million people on treatment by 2005. We also support – and are promoting – the UNAIDS 'Three Ones' initiative. This aims to ensure that international help takes its lead from, and supports, national programmes.

This policy outlines the UK's support for efforts to provide increased, and eventually universal, access to treatment and care for people with HIV and AIDS. This help must be part of a package that includes programmes to prevent the spread of HIV, as well as to reduce the social and economic impact of AIDS. Our plans to do this are contained in *Taking Action: The UK's Strategy for Tackling HIV and AIDS In the Developing World*, which is being published at the same time as this policy.

The last few years have seen drug prices drop significantly. Evidence shows that treatment programmes are at least as effective in poor countries as they are in rich ones. It is now much better understood that linking treatment and care with prevention initiatives and programmes to reduce the social and economic impact of AIDS can make each of these activities more effective.

Central to the UK's efforts will be the needs of poor people and ensuring that women and children – who face a disproportionate burden – are reached by treatment and care programmes. We will work to strengthen health services. The UK will also work to make sure that our response to AIDS helps support longer term development objectives.

In doing all of this we will work in partnership; we cannot do this by ourselves. We will work with developing country governments, with people with HIV and AIDS, civil society, our G8 partners and other donors, with multilateral agencies, business, NGOs, local communities and others. With sustained effort and commitment we can, in time, work to provide universal access to good quality treatment and care for everyone with HIV and AIDS worldwide.



Hilary Benn
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1.1 The AIDS epidemic continues to grow and now affects every country. It is one of the greatest threats to poverty reduction. 58 million people have been infected with HIV and 20 million have died – daily there are over 13,000 new HIV infections, and nearly 8,000 deaths from AIDS.¹ 6 million people in developing countries are estimated to require antiretroviral therapy (ART) – only 400,000 are receiving it.² In sub-Saharan Africa, AIDS is the leading cause of death.

1.2 The UK supports efforts to provide increased, and eventually universal, access to treatment and care for people with HIV and AIDS.*

1.3 We support the WHO and UNAIDS '3 by 5' framework and its goal to provide ART to 3 million people in developing countries by the end of 2005, of which 2 million will be in Africa.³ The UK's treatment and care activities will operate within, and be supportive of, the '3 by 5' framework.

1.4 While encouraging governments to set their own national plans, we will advocate for equitable provision to women and children and, if appropriate, encourage a target of at least 50 per cent of treatments being directed to women and children. The benefits of such an approach would include the prevention or delaying of children becoming orphans.

1.5 Recent years have seen increased levels of activity amongst donors, foundations, multilateral organisations and national governments to tackle AIDS. These are welcome, and necessary. But if poorly coordinated, these different efforts run the risk of creating a sort of 'treatment chaos' of competing and contradictory approaches. The UK will seek to enhance coordination efforts, and to minimise the potentially distorting effects of 'treatment chaos'. We will continue to promote the UNAIDS Three Ones approach, which aims to increase coordination between international initiatives, and for them in turn to take their lead from, and support, national efforts to tackle HIV and AIDS.

Treatment and care

1.6 A comprehensive approach to treatment and care for people with HIV and AIDS should include a wide range of elements, including: community, and national, treatment, care and prevention education and awareness programmes; voluntary counselling and testing; material, medical and psychological support for people with HIV; programmes to challenge stigma and discrimination, which

* HIV and AIDS

Non-governmental organisations (NGOs) and people with HIV and AIDS consulted by the UK in the development of this policy raised concerns about the terminology "HIV/AIDS". They say this implies HIV is the same as AIDS or that HIV is inevitably a 'death sentence'.

We have used the term HIV to refer to the virus which is transmitted, and AIDS to describe the condition where a person becomes ill because of underlying HIV infection.

Where we are describing the topic or subject e.g. "national AIDS strategy" we use the term "AIDS" to be inclusive of the full social and political concept as well as the medical conditions.

HIV/AIDS is used where it is the title of an existing document or work programme.

can help encourage people to be tested and to take up treatment and access care; prevention and treatment of opportunistic infections (such as tuberculosis – TB) and sexually transmitted infections; home based and palliative care; ART, including essential laboratory and clinical backup; systems of drug management; bereavement support; and operational research to build the evidence base.

1.7 The last few years have seen growing evidence of the effectiveness of treatment programmes in poor communities and countries,⁴ significant reductions in the price of antiretrovirals (ARVs),⁵ and a greater understanding of the fundamental importance of treatment and care in tackling HIV and AIDS.

1.8 There is now an international consensus that treatment and care are essential parts of an effective and comprehensive response to AIDS. As well as the direct benefits for people receiving it, access to treatment and care can help prevention efforts and programmes designed to minimise the impact of AIDS. Availability of ART in particular gives people a reason to seek testing, and it might reduce the level of transmission in a population. Treatment and care, including ART, can be seen to help the poor if their provision helps individuals and their communities to maintain their livelihoods and economic productivity, to reduce 'short termism' and asset stripping, and to prevent or delay orphaning and widow-hood, thus mitigating the factors that cause further vulnerability to infection.

1.9 However, HIV should be recognised as a life-long, chronic disease. Effective treatment and care requires that the elements outlined above are integrated and balanced appropriately. For instance, ART cannot be provided in isolation. Its provision requires essential laboratory and clinical backup, voluntary counselling and testing, awareness raising efforts to promote understanding of treatment and adherence to it, treatment for opportunistic infections such as TB, communication efforts to tackle stigma and discrimination and other interventions. Doing all this is quite complex and requires a relatively developed health service, incorporating actions by the individual, the community, local health centres and district services as well as tertiary services where appropriate and realistic. If treatment and care is developed in the context of HIV being a life long, chronic disease, then increased provision should contribute to stronger health systems, and therefore promote more equal access to healthcare.

1.10 There are risks involved in the increased provision of treatment and care. As noted above, different elements of treatment and care need to be integrated and balanced. Furthermore, increased commitment to treatment and care can lead to provision at the expense of attention to prevention efforts and programmes to reduce the social and economic impact of the disease. There is a danger that AIDS could come to dominate health provision to the exclusion of effective action to tackle other diseases and health needs. Despite recent price reductions, ARVs are still relatively expensive.

1.11 Increased emphasis on treatment and care must be accompanied by prevention efforts and programmes to reduce the social and economic impact of the disease. Comprehensive programmes to tackle AIDS should be supportive of broader national development objectives.

The role of the UK in expanding access to treatment and care

1.12 The UK will work in countries, and regionally, to support treatment and care programmes that are:

- focused on the needs of the poor, women and children;
- involve individuals and communities affected by HIV and AIDS in decision making;
- help to strengthen the systems that deliver health services, and support prevention and impact mitigation efforts;
- promote greater coherence between different international initiatives, and, in turn, their links to country-led programmes; and
- are informed by evidence, and consistent with broader developmental objectives.

1.13 The UK is committed to strengthening health services as part of longer term development objectives, and will not support 'vertical' or 'parallel' programmes whereby HIV and AIDS treatment and care programmes are developed separate to national health services. With an expanding range of new international and national initiatives on AIDS, 'vertical' approaches are likely to clash with one another, weaken national responses, and run the risk of undermining the country's health delivery services. In terms of treatment, this is particularly important in relation to medicines and diagnostics procurement, management and supply, as well as rational selection, use and monitoring of medicines. Where 'vertical' or 'parallel' programmes are operating, the UK will focus on strengthening health services.

1.14 The UK will support an active programme of operational research within programme implementation, to build the evidence base and contribute to effective programmes worldwide. We will help coordination and information sharing between the various research initiatives concerned with the delivery, and the impact, of HIV and AIDS treatment. In particular we will back research efforts that support access to treatment by the poorest and most vulnerable including women and children.

1.15 In deciding the appropriate mix of elements in responding to AIDS there is no blueprint that can be applied everywhere. The UK will support countries to identify appropriate plans based on local needs. This policy sets out a framework of guidance and advice on the desirability and appropriateness of specific elements for those involved with the development of treatment and care programmes in developing countries.

1.16 At the international level the UK will work with other donor governments, multilateral institutions, the private sector and civil society to support efforts to provide increased, and eventually universal, access to treatment and care. The principles noted above will be applied at all times. The UK will support research into better pro-poor treatments and diagnostics, including treatments for children.

The principles underpinning the UK's response

2.1 Treatment and care programmes should be pro-poor, gender, child and equity focused, and should prioritise the access of the poorest and most vulnerable. The UK will advocate for equitable provision for women and children and, if appropriate, we will encourage countries to set a target of 50 per cent of treatments being directed to women and children. The burden of HIV and AIDS falls disproportionately on these groups. To deliver equitable, pro-poor programmes, that maintain social support networks and minimise the impact of the disease, women and children should have equitable access to treatment and care. To do this, the barriers that suppress demand for treatment need to be identified and addressed, including stigmatisation, the costs of travel to health services as well as treatment itself, and lack of information and support. Factors that affect the supply of services include discrimination in the practices of service providers as well as bias in policy and resource allocation, and issues around human resource capacity. The engagement of community based organisations in the preparations for and delivery of treatment and care is critical to increasing poor and vulnerable people's access to services, not least in the areas of ensuring people understand the realities and requirements of treatment (treatment literacy) and the importance of adhering to drug regimens.

2.2 People affected by HIV and AIDS – especially poor people and women – should be involved in decision making about national treatment and care programmes. The UK will promote the principle of Greater Involvement of People with AIDS (GIPA) by supporting the development of mechanisms to involve them in policy and management discussions. The UK will also support legislative reform that combats discrimination and helps people with HIV and AIDS to be more involved. Civil society, including the media, has a primary role in promoting an open debate about treatment and care, and in increasing the accountability of governments for implementation of their policies. The UK will support efforts to discuss sex, sexuality and AIDS openly.

2.3 Programmes should support sustainable health services, and long-term prevention and impact mitigation. It is vital that treatment and care is developed in such a way as to strengthen health service delivery, in part because HIV is a long-term condition, and in part to contribute to broader development goals – including the other health related Millennium Development Goals (MDGs).⁶ 'Parallel' and 'vertical' systems to deliver treatment and care can undermine existing health services delivery. Action should include community and faith based organisations, NGOs, the private sector and trade unions. Where possible programmes should support and enhance prevention and impact mitigation efforts, which address both immediate risk and people's underlying vulnerability

2.4 Programmes should ensure that international and national efforts support country-led programmes. Increased commitment and action on the part of the international community and national governments is welcome, but it raises the risk of 'treatment chaos'. Coordination of efforts is vital. The UK is committed to promoting the Three Ones framework adopted by donor and recipient countries in Washington in April 2004. Countries and donors are encouraged to develop: one agreed

HIV and AIDS action framework that provides the basis for coordinating the work of all partners; one national AIDS coordinating authority; and one agreed country-level monitoring and evaluation system. Where programmes are large, it is vital that they are integrated into central planning processes in the countries of operation: e.g. macroeconomic management, national and regional budgets, and poverty reduction strategy papers (PRSPs).

2.5 Programmes should be informed by evidence, and should be ambitious in their desired effect on health and development. AIDS is a threat to development. Programmes should work to support broader developmental objectives. Opportunities to maximise the potential of treatment and care to strengthen health services should be exploited in order to support the attainment of other MDGs. The UK will support the improvement of the evidence base in its work, including, vitally, through support for operational research as an integrated component of treatment and care programmes so as to learn by doing and to build the evidence base.

Effective treatment and care

3.1 Treatment and care for people with HIV and AIDS has to be firmly linked to prevention efforts and programmes to reduce the social and economic impacts of the disease. Unless new HIV infections are reduced through prevention programmes, treatment will be unsustainable since it will be unable to keep pace with all those who need it. The positive effect of treatment availability on the success of prevention programmes is less clear, but it is likely that it will assist by bringing more people into HIV testing and behavioural counselling. Stigma and discrimination will be reduced as more people know, and disclose, their status, and infectivity could be reduced as people start on ART.⁷

3.2 This policy will not discuss in detail the nature of different elements of treatment and care. We look to WHO and UNAIDS to provide technical and clinical guidance. This chapter will look at the relationship and sequence of the main elements of effective treatment and care, as well as considering the wider environment. The next chapter discusses the way in which different country contexts will impact on treatment and care.

3.3 When we talk about supporting efforts to provide increased, and eventually universal, access to treatment and care, we refer to:

- deepening the response by expanding the range of services;
- widening the response by increasing access for different groups of people; and
- strengthening the response by building the political and social commitment and capacity to act.

Deepening the response

Elements of a comprehensive treatment and care response include:

- Education and prevention
- HIV counselling and testing with informed consent, in health facilities and in services targeting vulnerable and difficult to reach populations
- Community mobilisation
- Support for positive living, including social protection, nutrition, welfare and psycho-social support
- Programmes to address stigma and discrimination
- Psycho-social care and peer support
- Palliative and home-based care
- Prevention and treatment of opportunistic infections and sexually transmitted infections
- Prevention of mother-to-child transmission [plus] (PMTCT [+]).
- Human resources management, including training and quality assurance
- Treatment literacy
- Antiretroviral therapy and monitoring, including essential laboratory and clinical back-up, and systems for drug management
- Adherence support
- Bereavement support
- Operational research

3.4 Introduction of different elements of treatment and care need to be appropriately phased. For instance, initiation of ART at national or sub-national level should only start if a set of minimum conditions are met, including community preparedness, counselling and testing with informed consent, personnel trained for ART provision and follow-up, and uninterrupted supplies of ARV drugs. One key element is the training, support, accreditation and quality control of providers, including the private and public sectors.⁸

3.5 However, some elements can be scaled up simultaneously to – or in advance of – others, if planned correctly.⁹ For instance, education, community mobilisation, support for positive living, palliative care, prevention and treatment of opportunistic infections, and prevention of mother-to-child transmission are important in their own right and might be scaled up ahead of other elements. There is no one blueprint for expanding different elements of treatment and care, and plans should respond to analysis of local needs and capacities, supporting national priorities.

3.6 Experience from pilot programmes has shown that there are many ways in which we can integrate prevention and care activities,¹⁰ through entry points which allow access to both prevention and care, through service delivery points which can provide both prevention and care interventions, and through referral networks which allow people to move between services as their needs change. It is vital that the principle of GIPA is followed in designing services that are responsive to community needs.

3.7 HIV counselling and testing with informed consent is the key point at which people will learn their HIV status and be offered care services as well as receiving behavioural counselling and advice on prevention. It is important that prevention information and advice is offered to those who test both HIV positive and HIV negative. Greater provision of HIV treatment should create greater demand for counselling and testing services¹¹ and in most countries counselling and testing services need to be significantly expanded – in terms of both geographical reach and provision at community level or through community networks – as other HIV programmes are rolled out. Otherwise limited availability of testing and counselling is likely to act as a bottleneck to take up of treatment and care.

3.8 Sexual and reproductive health services – including clinics for treatment of other sexually transmitted infections – also act as an entry point to all aspects of prevention and care.¹² Antenatal services provide access to programmes to prevent mother-to-child transmission of HIV and also allow HIV positive women to access treatment and care during and after pregnancy – and receive advice for future pregnancies.¹³ Outreach services for targeted populations – including sex workers, men who have sex with men and injecting drug users – spearhead prevention programmes but can also act as an important channel for information about all HIV services, including testing, treatment and care.

3.9 As movement is made towards scaling up both treatment and prevention programmes, opportunities exist to combine their provision. Programmes for people with HIV and AIDS and their families, including home based care, will mainly provide care services. However, they should also consider the HIV prevention needs of people with HIV and their partners. Widespread access to HIV and AIDS treatment could bring large numbers of people into health care, providing new opportunities for health care workers to deliver and reinforce HIV prevention messages and interventions. Peer education and counselling has been seen as an effective method of providing prevention programmes, and increasingly peer support – including groups for people with HIV and AIDS – can provide treatment education, support people to cope with side effects of treatment, promote adherence, provide ART and provide bereavement support.¹⁴

3.10 Other health services can also act as entry points for treatment and care. In particular the TB and HIV and AIDS epidemics fuel one another. Increased collaboration between TB and AIDS programmes is urgently needed. TB programmes have the potential to recruit large numbers of people into HIV treatment if joint service provision or effective testing and referral between TB and AIDS services is developed. TB programmes can also assist in delivery of ART, care and support and HIV prevention. ART has been demonstrated to reduce TB in individuals with both HIV and TB infection, reinforcing the need for effective diagnosis of TB in people using HIV and AIDS treatment and care services.¹⁵ TB preventive therapy also remains important.¹⁶

3.11 The UK will work to link comprehensive treatment and care with efforts to reduce the social and economic impact of the disease, including through:

- increased education for health workers, family, neighbours, and community members;
- advocacy and legal aid; and
- provision of care for those caring for people with HIV and AIDS.

Widening the response

3.12 The UK supports the pursuit of the '3 by 5' target of 3 million people on treatment by 2005 and, in the longer term, universal access to treatment for HIV and AIDS. Universal access is the most effective way of ensuring access by poor people and therefore remains the UK's long-term objective. However, capacity and resource constraints mean that phasing is inevitable in many countries. Pro-poor and equity considerations should be paramount in considering issues of targeting and phasing.

3.13 Discussions around the allocation of scarce resources raise many practical and ethical issues. Some advocate targeting women as a proxy for targeting the poor, which could lead to ART programmes being provided through clinics for prevention of mother-to-child transmission. Others argue that pro-poor targeting could encompass targeting of front line health and education workers, to ensure staff can maintain services accessed by the poor. In addition, such provision can be seen to protect developmental gains.

3.14 In terms of the '3 by 5' target, while the UK supports governments in setting their national plans, we will advocate for equitable provision to women and children and, if appropriate, encourage a target of at least 50 per cent of treatments being directed to women and children. The burden of HIV falls disproportionately on these two groups, and yet the needs of women and children are often sidelined. Increasing rates of infection among women of all ages highlight the importance of addressing the needs and rights of women and young people, particularly young girls. In sub-Saharan Africa women make up 57 per cent of adults aged 15-49 with HIV, whilst women and girls represent 75 per cent of young people aged 15-24 with the disease.¹⁷ Women and girls' vulnerability to HIV is due to their greater biological and social susceptibility to the disease, including in terms of sexual coercion and violence, and unequal gender relations. Women and girls have a disproportionate caring role, and are expected to care for others even before caring for themselves.

3.15 Children and young people are also significantly affected by HIV and AIDS. 15–24-year-olds account for half of all new HIV infections worldwide.¹⁸ Children with HIV and AIDS are likely to be orphaned, suffering emotional and psychological trauma. They consequently have limited support to deal with their own condition. Most households caring for orphans and other vulnerable children – including child headed households – do not get any support. Where they do it is more often from community and faith based groups than from public bodies. Priority should be given to approaches which combine prevention of mother to child transmission to reduce the risk of children being born with HIV, and the provision of long-term treatment and care for parents so as to prolong the lives of parents to avoid, or delay, orphan-hood. In addition, children and young people with HIV and AIDS should have access to treatment and care to allow them to live productive lives. The UK has endorsed UNICEF's 'Strategic Framework for the Protection, Care and Support of Orphans and Children made vulnerable by HIV/AIDS'.¹⁹

3.16 Other marginalised and vulnerable groups requiring special attention include men who have sex with men, injecting drug users and sex workers. Services need to be adjusted to meet their needs. In terms of hard to reach populations, it will be important to take account of the health needs of people affected by conflict, including refugees and internally displaced persons. Limited provision of, and access to, general health and other services, as well as the risk of further population movements mean that even the core elements of treatment and care are likely to be compromised. The UK will support efforts to better understand how treatment and care can be provided to these marginalised groups.

3.17 Despite the issues noted above, lack of facilities in the remotest areas, the perceived need to treat key workers in public services and overall resource constraints mean it is unlikely that all of the most vulnerable people and groups in any country will be able to receive priority treatment. Experience suggests, however, that minimal use of social selection criteria is important to ensure equity. Lessons learned from current programmes indicate that, where choices about who is to receive treatment are unavoidable, it is important that front-line health providers are not the ones who establish eligibility criteria. Decisions about prioritisation should be made through a transparent, nationally led process on the basis of the widest possible consultation. Poor communities, vulnerable groups and communities of people living with HIV and AIDS should all be involved in decisions about targeting and phasing. It is ultimately not the role of donors to decide who should, or should not, receive treatment as it is rolled out.

Strengthening the response

Strengthening health services to deliver treatment and care

3.18 It is important not to underestimate the resources required to deliver treatment and care. HIV is a chronic disease and massive improvements in the availability and quality of health services in most countries with major epidemics are essential before even basic provision becomes feasible for the majority of people living with the disease and their families and carers.

3.19 Treatment and care will have to be delivered through district and community services as well as through provincial or regional hospitals. Ensuring access to quality services for all – including poor and marginalised populations – requires the availability of services at the lowest level of the health system and amongst non-governmental providers of services to hard to reach populations. This will require a reallocation of human and infrastructure resources (including a functioning system of support, referrals, equipment and running costs) to the areas with greatest needs.

3.20 A particular area of concern, and one which the UK is leading on internationally, is the issue of human resources for health. Health workers are faced with a triple burden: dealing with AIDS in their working lives, potentially being infected themselves, and caring for those around them outside work. In some countries the additional stress of AIDS is tipping already stressed systems into crisis. This is an emergency that requires a twin-track approach: continued attention to longer-term development coupled with immediate short-term measures to boost human capacity and fast-track innovative initiatives in the health sector. Human resource planning for ART needs to be integrated into sector-wide human resource plans.

3.21 The UK will support countries to develop innovative and effective approaches to human resource development, whilst mitigating the impacts of AIDS on service delivery. This will include efforts to prevent 'burn-out' due to the impact of AIDS on the morale of carers, to address ill health and to develop more flexible forms of working.

3.22 Programmes will need to work with intermediate personnel such as medical assistants, retired health care workers or informally experienced carers. Linkages or integration with other health programmes, such as for TB, create opportunities for efficiencies in human resource sharing and maximise the potential for treatment and care to build health systems capacity. Lower level medical personnel in treatment programmes need to be well integrated into existing systems and management structures. In addition, attention and training must be provided to community or lay health workers, whose role in the provision of care, and in treatment support, particularly around adherence and treatment literacy, will be vital.

3.23 We will also make sure that the UK's own practices for recruiting to the National Health Service (NHS) do not further exacerbate countries' human resource constraints. We will take action to strengthen the impact of the Code of Practice²⁰ on the recruitment of health care workers, to prevent the use by the NHS of agencies that recruit health care staff directly from developing countries unless a bilateral agreement has been negotiated with the country concerned. We will encourage independent sector agencies and employers to adopt consistent principles.

3.24 The provision of technical support can play an important role in filling gaps in knowledge and building capacity within countries to design and implement an effective AIDS response. Support for improved monitoring and evaluation and strengthened health management information systems will be important. However, experience with technical assistance has taught us that such assistance is probably most effective in capacity building in the longer term when it is managed by government rather than donors and builds on existing local capacity.²¹ In the context of AIDS, technical support should be part of the national AIDS strategy.

3.25 Medicines and diagnostics procurement, management and supply, as well as rational selection, use and monitoring, will be vital for the effective implementation of ART. Health care products, including medicines whether procured commercially, at differential prices or through donations, should ideally work through existing health care systems, including drug procurement, supply and management systems such as national medicine stores. The capacity of such systems should be strengthened as appropriate and in relation to general issues around increasing access to medicines, and in preference to the establishment of parallel systems for AIDS.

3.26 National AIDS strategies should give due concern to issues of leakage and diversion of medicines and other health care products. Action to tackle poor quality medicines, including counterfeits, should be part of national frameworks to ensure consistent quality. Regulatory and registration processes for new medicines should be strengthened. Medicines for the treatment of HIV and AIDS and opportunistic infections should be included in essential medicines lists and be covered under national drugs policy.

3.27 Individual country and regional programmes should purchase drugs on the basis of affordability, quality, safety and efficacy, whether these are generic or branded medicines. National drugs policy and essential medicines lists should reflect this. Intellectual property frameworks in countries should incorporate appropriate safeguards, including freedom to use the flexibilities contained in the Trade Related Aspects of Intellectual Property (TRIPS) agreement as appropriate.²² It is worth noting that least developed countries do not need to comply fully with TRIPS until 2016.

The private sector, trade unions, NGOs and community groups

3.28 It will be important that governments and others in society work together. This will include the private sector (both as health care providers and as employers), community based organisations, faith based groups, non-governmental organisations and trade unions. Community groups and communities of people with HIV and AIDS will be particularly important.

3.29 In many developing countries providers in the formal and informal private sector are an important source of information and of drug treatment, especially for sexually transmitted infections. Private providers such as doctors, nurses and pharmacies and traditional and informal providers such as drug sellers are often chosen in countries with weak public services or to minimise stigma. Care should be taken not to crowd out private providers. It will be important that the distribution of ARVs occurs in the context of practices and procedures that promote rational drug use and encourage patient adherence, limiting the development of resistance. National government policies need to take account of the different private providers of services, including ART, and define strategies for training providers and monitoring the quality of care people receive.

3.30 Workplace programmes are an important source of treatment and care for employees.²³ The UK has a workplace policy for employees of DFID, the Foreign and Commonwealth Office and the British Council that includes the provision of full medical treatment – including ART – for all HIV related conditions. The policy currently extends to employees and their partners. It is under review.

3.31 By providing employees with access to treatment and care, workplace policies help maintain company activities by reducing absenteeism and sustaining employee productivity. Increasingly, companies are considering extending employee schemes – including ART – to provide for partners, dependents and local communities. This is partly a moral decision in recognition of the need of these groups, and partly because of adherence problems if employees share ARVs with partners, dependents and members of the local community who are unable to access treatment elsewhere. This directly threatens the company's own activities, and increases the risk that resistance to ARVs will develop.²⁴

3.32 The extension of workplace policies into the community offers valuable new capacity for provision. Care must be taken to support existing health delivery services, and to protect access by poor communities. Work should also be done where possible to apply lessons and successful models in small to medium sized enterprises and in the informal sector, including in relation to provision of treatment and care, and raising awareness of AIDS and the services that are available. Trade unions can play an important role in promoting effective workplace policies, and supporting efforts to extend provision to other groups of people.²⁵ The UK will support employers, business associations and trade unions to maximise the value of this work.

3.33 Community involvement in the design and delivery of ART programmes will be essential for the delivery of quality services in an equitable and accountable manner. Community groups, faith based and other civil society groups should be partners in provision of treatment and care. These groups should be supported in this work, and consideration should be given to direct financial support where direct budget support cannot accommodate these groups.

3.34 To reach poor communities it will be vital to stimulate and sustain those communities to help in the provision of treatment and care. Community members should be trained to act as intermediaries between treatment centres and communities. Community or lay health workers will be a vital part of adherence support and treatment literacy. Community members should be encouraged to participate in health care advisory boards. Due attention should be given to the role of traditional health providers. Peer to peer groups should be encouraged.

3.35 The extent and effectiveness of community engagement in treatment and care will be affected by existing social inequalities. It cannot be assumed that communities are homogeneous or harmonious. In communities with marked social hierarchies and differences in power between men and women, castes or other social groups, community action is likely to be more difficult. In such contexts, careful analysis and preparation will be required to ensure that all sections of a community, including the most vulnerable, are being engaged.

3.36 Greater involvement of people with HIV and AIDS will help develop community capacity and also challenge discrimination, yet in the early stages people with HIV and AIDS may fear negative consequences if they are open about their status.

Creating demand, and tackling stigma and discrimination

3.37 Analysis of the social and political constraints on demand needs to be given as much priority as questions about, and analysis of, supply-side issues. Evidence to date suggests that, particularly in low-income countries, lack of demand is a bigger issue than lack of supply, with people not coming forward for HIV testing and treatment even when it is available.²⁶

3.38 There is a great deal of misinformation and fear around AIDS that affects people's readiness to come forward for testing, treatment and care. Stigma and discrimination are rife.

3.39 There are constraints on demands from women that need particular attention. Women are likely to wait longer before seeking treatment and services until they are at an advanced stage of infection and suffer from related opportunistic infections, many of which (such as TB) are themselves highly stigmatised. Women are more likely to suffer from discrimination and, in some cases, violence, once their HIV-status is known.

3.40 Civil society, the media and the state must work together to ensure there are informed debates about the realities of AIDS, with a focus on early testing and 'knowing one's status'. The involvement of people with HIV and AIDS in debates has served to reduce fear and discrimination.²⁷ The UK will support programmes aimed at enhancing the public information environment, including through media campaigns and reform of the media environment, and in terms of NGO, community group, trade union and private sector education and awareness campaigns.

3.41 The UK will publish guidance to our country programmes on AIDS communication issues addressing HIV prevention as well as treatment. This will emphasise the importance of communication efforts being coordinated and linked to national communication strategies that make the link between prevention, treatment and care.

3.42 Stigma and discrimination must also be dealt with through appropriate legislation at the national level to protect human rights, including anti discrimination legislation, legislation to regulate the conduct of public institutions like the police, and to guarantee individuals access to services. Stigma and discrimination must also be challenged at the family and community level, as well as in all procedures and practices of public and private organisations.

3.43 In addition to stigma and discrimination, lack of information and support, one of the primary factors affecting demand is cost, including the additional costs of transport to health facilities and concerns about the costs of additional food that might be required to ensure the effectiveness of treatment.

3.44 Other possible costs include user fees. The UK is committed to ensuring that affordability is never a barrier to accessing health, including care and treatment. User fees for basic services act as a barrier to access for poor people.²⁸ Furthermore, the evidence shows that paying for treatment undermines adherence to ART.

Research issues on treatment and care

3.45 Whether or not capacity constraints and lack of affordability prevent universal access, the introduction of treatment necessitates research and development of best practice in the medium term. The impact of treatment on HIV prevention and transmission within a population and the implications of different methodologies for adherence are key areas for further research. The UK will support efforts to establish evidence on the impact on prevention. It is also important that research is done on the links between HIV and AIDS treatment and care and that for other diseases. This is particularly important for TB, where treatments for TB and HIV and AIDS can both positively and negatively impact on one another. Another important area for further research is around provision of treatment and care for internally displaced persons, refugees, and other transient populations. Strengthened monitoring and evaluation frameworks, including the use of health management information systems, will be an important part of effective operational research.

3.46 In addition to operational research there are important research needs to develop more pro-poor treatment approaches, including to address issues of adherence, rational sequencing of drugs, paediatric treatments including paediatric ART, and future treatment options, as well as future preventive technologies including vaccines and microbicides.

3.47 Research into issues affecting children is urgently required. There are few children born with HIV in rich countries and consequently a limited range of formulations and appropriate treatments for children with HIV and AIDS, the majority of whom are in poor countries. More needs to be known about how and when to provide treatment to children. The UK will prioritise research efforts to allow poor children to access treatment and care.

4.1 Strategies for UK support to country programmes should be built on an assessment of the country context, including identifying local needs, issues and existing service provision. The UK will support the phased introduction of treatment and care to help move towards comprehensive programmes.

4.2 Some of the major factors specific to different country contexts that will impact on treatment and care provision and which should be assessed in any initial appraisal include:

- leadership and governance environment;
- policy, programming and financing context – such as the national treatment strategy and the involvement of initiatives such as the WHO and UNAIDS '3 by '5 initiative;
- level of economic development;
- stage and rate of growth of the epidemic;
- an assessment of health delivery systems; and
- community preparedness.

4.3 These factors, the effective elements of a response, and the principles underpinning the UK's response are set out in a diagram in Annex 3.

Leadership and governance environment

4.4 Leadership and governance have a significant impact on a range of issues, including demand creation and the ability to tackle stigma and discrimination. Experience in countries such as Uganda has shown how important leadership is in raising awareness, reducing stigma and encouraging people to be tested. Commitment at the level of the president or prime minister provides much needed momentum to efforts at every level of society. But leadership is not only confined to the head of state. It is also important for regional, community, faith based, NGO, business and trade union leaders and, vitally, for people with HIV and AIDS.

4.5 Governance can affect the development of treatment and care, including in terms of whether a country is in a state of conflict or post conflict, whether it is a weak or failing state, or whether a state is stable. If the institutional structures and delivery mechanisms of the state are weak and under-performing, it will be much harder to implement effective long-term, chronic treatment and care. This is especially the case for ART. Ineffective monitoring of patients, and inefficient and

irregular medicine and diagnostics supply and distribution could create high levels of resistance. It is also much harder to deliver treatment and care if there are limited service delivery mechanisms to build upon. Conflict and post conflict states are likely also to have refugees and internally displaced persons who will be difficult to reach with treatment and care. Even where treatment and care can be made available, there is a significant risk that further population movements will mean adherence is low and treatment is compromised. In addition, there remain questions about who should pay. Any assessment will have to take account of the risks and complexity of provision of treatment and care to these groups.

4.6 Leadership and governance factors come together around the structures that encourage, and the space that is available for, civil society and other non-state actors to be involved in decision making. Civil society, including people with HIV and AIDS, has a key part to play in designing, co-ordinating, raising awareness and delivering responses. Free media can contribute to this space, and towards the creation of the necessary demand amongst poor communities to access services on offer. Furthermore, accurate reporting and media campaigns can help to deliver appropriate messages, including the fact that there is no cure for HIV or AIDS.

Policy, programming and financing context

4.7 In considering the elements of effective treatment and care it is vital that a thorough assessment is undertaken of the impact of existing plans, including the national AIDS strategy and initiatives implemented by other donors, foundations and multilateral agencies.

4.8 National plans for treatment and care may take a variety of forms and should be part of broader poverty reduction and development strategies. The potential for treatment and care to strengthen health services will be highest if national treatment strategies stress ART as part of a package of treatment and care, integrated within broader health sector plans, and addressing human resource development across the health service. Plans should also look beyond the public health sector to private and non-health agencies that need to be included. Proposals to access external funding, or to work with international programmes, should be consistent with, and supportive of, the national AIDS strategy.

4.9 The field of AIDS is increasingly crowded and it is important that new activity helps develop effective links. Major international initiatives currently planned and being implemented include:

- The WHO and UNAIDS '3 by 5' initiative
- The US President's Emergency Plan for AIDS Relief
- The Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund)
- The World Bank Multi-country HIV/AIDS Programme (MAP)
- The William J Clinton Foundation HIV/AIDS Initiative
- The Accelerating Access Initiative.

Further information on all of these initiatives is included in Annex 2.

4.10 The UK believes that international initiatives need to work together to improve coordination and coherence, and that they should ultimately get behind country led strategies. The UK is committed to the promotion of the UNAIDS-led Three Ones framework for agencies to support country led responses, in particular:

- one agreed HIV and AIDS action framework that provides the basis for coordinating the work of all partners;
- one national AIDS coordinating authority, with a broad-based multi-sectoral mandate; and
- one agreed country-level monitoring and evaluation system.

Treatment and care should be fully integrated within the national HIV and AIDS action framework, the national AIDS coordinating authority and the monitoring and evaluation system.

4.11 The UK will work particularly with national governments to promote effective partnerships in countries between different agencies providing assistance. For example, it is important that technical support provided under the WHO and UNAIDS '3 by 5' initiative helps governments access financing from the Global Fund. Where programmes such as the US President's Emergency Plan or the Clinton Foundation are present alongside national programmes it will be important to make links and avoid duplication or parallel services.

4.12 An appraisal of who is doing what may also identify important gaps in the comprehensive response. Where agencies are focusing particularly on treatment it will be important to ensure that other aspects of care – including palliative care and services for prophylaxis and treatment of opportunistic infections – are also provided. Where responses prioritise the public health sector,

it may be appropriate to strengthen the capacity of civil society and others to also support the response. Where attention to treatment jeopardises the sustainability of HIV prevention programmes, it will be important to advocate for and support continued prevention efforts.

Economic development

4.13 Economic issues have to be considered within the broader context of questions of equity, rights and social justice. However, the degree of economic development of a country inevitably influences the level of public action that can be taken on critical problems like AIDS. Many elements of treatment and care are cost effective in poor as well as wealthier countries. However, there remains a lack of clarity around the cost effectiveness of ART, particularly in low income countries.

4.14 The UK supports the introduction of ART in low income countries as well as in middle income countries.

4.15 In a middle income country the government is likely to be neglecting a cost effective health investment if it does not provide ART. Cost effectiveness is less clear in low income countries where access to other more cost effective health interventions than ART are generally already limited. However, there are a number of reasons to conclude that ART is more cost effective than some narrow assessments suggest, and therefore appropriate in poor countries. Potential external or value added benefits from ART include:

- strengthened HIV prevention efforts;
- reduced emergence of resistant HIV strains;
- the sustaining of economic activity; and
- the prevention, or delaying of the emergence, of a generation of orphans.

4.16 AIDS can have a serious impact on economic activity. Whilst the macroeconomic impact of a generalised AIDS epidemic is impossible to prove, it is often estimated in the range of a 0.5 per cent to 2 per cent reduction in economic growth.²⁹ Such a reduction in annual growth over a 20 year period is a significant macroeconomic impact and worth heavy investment to avoid. In most low income countries this would justify spending programmes designed to have a significant impact on the epidemic.

4.17 Whilst treatment for HIV and AIDS, including ART, can be argued to be cost effective in a poor country, it is important to bear in mind that the future costs of providing ART are uncertain. Key parameters in the long-term cost of ART are:

- the level of coverage and uptake of treatment;
- the degree of HIV resistance, and therefore the degree to which more expensive second and third line therapies are used;
- how long life is prolonged;
- what happens to the unit costs of treatment; and
- how successful HIV prevention efforts are in reducing the number of new cases.

4.18 A rough calculation of the future costs of ART – where there is 100 per cent coverage, life is prolonged for ten years or more, unit costs do not change, and where all 38 million people with HIV in the world require treatment – gives us a total cost of almost US\$46 billion a year, almost as much as all aid in 2004.³⁰ Whilst it is unlikely that the price of ARVs will continue to come down at the same rate as over the past three to four years, it will nonetheless be important to see further reductions in the overall cost of ART. This will require further reductions in the end user prices of medicines and diagnostics (including in terms of prices charged for medicines, and taxes, tariffs and other costs incurred), as well as efficiencies in terms of service provision.

4.19 Please see Annex 1 for a more detailed discussion of the economics of ART.

Stage and rate of growth of the epidemic

4.20 The stage of the epidemic in a country, including rate of growth and HIV prevalence rates in different populations, will have important implications for its treatment and care response, and the prioritisation of activities.

4.21 In early and concentrated epidemics, many countries fail to take sufficient action to prevent HIV transmission to control the epidemic effectively. Factors which delay responses include weak capacity, fear, discrimination and reluctance to deal with difficult issues such as sexuality and drug use. Yet the experience of Thailand illustrates the relative cost effectiveness of an early response, where highly effective prevention programmes are estimated to have averted millions of HIV infections.³¹

4.22 In early epidemics, treatment should be executed in a way that enhances the effectiveness and coverage of prevention programmes for populations at elevated risk, through linkages to the expansion of voluntary counselling and testing, activities to reduce stigma and discrimination and

programmes to reduce the underlying vulnerabilities of key groups. As such, treatment could be a useful addition to HIV prevention efforts in early stage countries, even low income ones, given the significant rewards of avoiding a generalised epidemic. Early planning for treatment and care, even when numbers needing care are relatively low, will also have benefits in building up capacity, and identifying appropriate delivery systems.

4.23 In generalised epidemics, it is harder for prevention programmes to achieve required coverage and impact. Expanding treatment will increase numbers who are able also to be reached by prevention programmes, including behavioural counselling. Widespread access to treatment could bring large numbers of people to be tested, and into health care, providing new opportunities for health care workers to deliver and reinforce HIV prevention messages and interventions.

Health services

4.24 Implementation and scaling up of treatment and care programmes in poor countries will require significant strengthening of weak health delivery services. It is important to make a careful analysis of the health system needs, and potential resources.

4.25 An assessment should look at:

- capacity of provincial and regional hospitals, as well as district and community level delivery systems;
- human resource constraints in state and non-state actors, including in relation to quality control, accreditation and training, impacts on other services, and necessary redeployments of staff to hard to reach communities;
- human resource support programmes to mitigate the triple burden on health workers (dealing with HIV and AIDS in their working lives, potentially being infected themselves, caring for those around them outside of the work environment);
- the capacity and geographic reach of community groups, NGOs, private health providers, pharmaceutical companies and employers;
- existing technical capacity in the health services and further capacity building needs;
- medicines and diagnostics management systems, including in relation to procurement, storage, distribution and supply. This should include assessment of the interface between medicines management systems, external differential pricing, donations or bulk procurement mechanisms, and any parallel management systems that threaten national systems;

- assessing mechanisms to counteract diversion and leakage of medicines;
- assessing medicines use policies, including national treatment guidelines, essential medicines lists, safety monitoring, medicinal promotion, and in relation to regulation and registration; and
- monitoring and evaluation systems, including health management information systems.

Community preparedness

4.26 Treatment and care outcomes will be better where people with HIV and AIDS and their communities are fully engaged in the delivery of programmes. Where treatment efforts are being supported through other programmes but community involvement is not in place, the UK will prioritise the development of community capacity to sustain treatment and care.

4.27 Communities need also to be fully involved in decisions over who receives treatment – yet the structures for such involvement do not exist everywhere. There are risks therefore that treatment roll-out will benefit relatively powerful groups and will further marginalise those who are already discriminated against. Civil society groups and community forums are needed.

4.28 In assessing entry points for treatment and care programmes the UK will therefore address:

- current formal or informal structures including NGOs, community based organisations, women's organisations and groups of people with HIV and AIDS;
- environmental factors such as stigma and discrimination and the determinants of this; and
- legal barriers or supports to community action, including human rights frameworks with which communities could engage.

Risks of expanding treatment programmes

5.1 The WHO and UNAIDS '3 by 5' initiative to get 3 million people on treatment by 2005, and new resources – for example through the Global Fund – are leading to unprecedented momentum to scale up treatment programmes. New commitment to making treatment available in developing countries is welcome, but the rapid roll-out of ART internationally implies a number of risks, which will need to be considered in the development of national plans. Risks relate particularly to the negative impact on health services and the development of resistant forms of the virus.

Impact on health systems

5.2 AIDS is having a severe impact on already weak health systems. It places increasing demands on all levels of health care delivery and has led to increased loss of, and diminished productivity among, service providers due to illness, attending funerals, caring for sick relatives, weakened staff morale and motivation, increased stress and death. Moreover, as treatment and care programmes are expanded, workloads have increased through the growing demand for services such as counselling and testing, diagnosis, prevention and treatment. There is some concern that these efforts will overwhelm weak health services, meaning not only that treatment for HIV and AIDS is of poor quality but also that staff and resources are diverted from providing other health services.

5.3 Delivery of treatment and care through 'vertical' programmes will increase the risk of negative impacts on broader health services. Some African countries report that health workers are increasingly being drawn from existing health services into AIDS projects – reducing service capacities. Where resources are drawn into 'verticalised' service delivery, essential capacities for management, supervision, information systems, commodity procurement and distribution are not sustainably developed in health services.

5.4 Treatment programmes may also shift undue focus onto the delivery of ARV drugs at the expense of other factors that exacerbate the impacts of AIDS – including food security, nutrition, access to primary health care and social security. They may also exacerbate inequity. Current and planned ARV programmes are largely concentrated in urban centres that have big hospitals and the infrastructure to manage treatment. In such circumstances, the initial beneficiaries are likely to be urban, better off and male.

5.5 Whilst there is understandable urgency in scaling up treatment efforts, responding to this challenge will not be possible through scattered projects and interventions. It will be important that treatment efforts are part of integrated health planning and are embedded in an accessible health system. Multilateral agencies – including WHO – which provide technical support to countries scaling up treatment should be challenged to make explicit strategies for developing strategies by which treatment efforts support health systems strengthening. Strategies for developing short-term capacity in health services are set out in Chapter 3.

The threat of resistant strains

5.6 The very dynamic characteristic of HIV can lead easily to resistance. Evidence indicates that adherence to treatment is the key priority to ensure that resistance does not get out of control. High levels of adherence are needed to ensure both good clinical outcomes (the viral replication becomes undetectable) and to avoid the emergence of resistant strains. However, even with very high adherence rates, there is evidence that resistance may still develop or, at least, treatments fail.

5.7 Despite concerns that conditions for treatment in developing countries were likely to lead to weak adherence, experience of pilots in deprived areas of some of the poorest parts of the world have shown that it is still possible to achieve good treatment outcomes with complex therapies.³² However, in order to replicate the successes of pilots it will be important to pay attention to ensure clinicians are trained and supported. Community involvement through treatment education and peer support will also improve outcomes.

5.8 The UK will also support WHO to put in place laboratory systems and sound monitoring systems to ensure that medicines do not cause adverse reactions.

5.9 If treatment programmes are launched but prove unaffordable, the universal access principle will be sacrificed and limited supply of treatment will have to be rationed, for example, in a black market. The poor and marginalised would lose access first. Rationing could accelerate the emergence of resistance if high and volatile prices interrupt people's treatment, and if counterfeit and substandard medicines are turned to.³³ It could also involve a lot of public or aid resources in subsidising services of no benefit to poor people.

Harmonisation and alignment

6.1 The field of AIDS is increasingly crowded and it is important that new approaches and initiatives help develop effective relationships between those who are trying to help, rather than further fragmenting the response.

6.2 The UK recognises UNAIDS' and WHO's roles in providing normative, clinical and technical guidance and supports the '3 by 5' initiative. The UK will work to help fulfil UNAIDS' and WHO's roles in support of national processes.

6.3 The UK advocates for greater harmonisation of donor programmes and international initiatives, to support national plans. Initiatives such as the WHO and UNAIDS '3 by 5' initiative, The President's Emergency Plan for AIDS Relief, The Clinton Foundation, The World Bank Multi-country HIV/AIDS Programme, and the Global Fund should bring new resources and capacity to strengthen the ability of national systems to deliver over the long term.

6.4 The UK supports the UNAIDS Three Ones approach. Treatment and care should be fully integrated within the national HIV and AIDS action framework, the national AIDS coordinating authority and the monitoring and evaluation system.

Access to medicines

6.5 Treatment and care for people with HIV and AIDS is significantly affected by broader issues related to access to medicines. The UK government published a document detailing its policy and plans in relation to access to medicines in June 2004.³⁴ The approaches to increasing access to medicines for the treatment of HIV and AIDS and opportunistic infections will be consistent with this policy, which includes:

- UK support for the August 30 Trade Related Aspects of Intellectual Property Rights (TRIPS) Decision allowing developing countries with no, or insufficient, capacity in their pharmaceutical industry to import copies of on-patent drugs in accordance with the provisions of the decision;
- work to improve provision of technical assistance to developing countries to ensure intellectual property legislation is appropriate, reflecting commitments under, and flexibilities covered by, the TRIPS agreement;
- commitments to continue working with pharmaceutical companies and other stakeholders to encourage best practice in relation to access to medicines, including for the treatment of HIV and AIDS and opportunistic infections;

- ongoing action to increase research and development into treatments for conditions disproportionately affecting developing countries, including HIV and AIDS; and
- continued support to strengthen healthcare.

The private sector

6.6 The private sector has an important role to play in expanding provision of treatment and care. The UK will work with the private sector, including international and national business coalitions and individual companies, to:

- increase affordability of medicines, diagnostics and other health care products necessary for treatment and care of HIV and AIDS;
- increase investment in medicines and new technologies for the treatment and prevention of HIV and AIDS and opportunistic infections; and
- further encourage the work of companies as employers in countries affected by HIV and AIDS in the provision of treatment and care. The UK will work with groups to enable the sharing of best practice and strengthen links between international, regional and national organisations of businesses and other employers.

Civil society

6.7 Civil society groups, including community based organisations, faith based organisations, NGOs and trade unions and workers' groups, have an important role to play at the national and international level. Concerted campaigns on the part of NGOs and community activists are in large measure responsible for the international community's change of policy in relation to support for ART in developing countries. The UK will continue to work with civil society to:

- share, and support, best practice on what works;
- encourage involvement of local communities in decision making, development and implementation of programmes; and
- support communication and advocacy efforts to extend treatment to poor and marginalised groups and to battle stigma and discrimination.

Short summary of economics of ARV treatment in comprehensive AIDS programmes

ART should be cost effective in middle-income countries that have higher levels of per capita health spending than low-income countries.

In a typical low income country ART – used as a ‘vertical’ programme separate from other AIDS interventions – is far from cost effective. If implemented on a maximum scale, a vertical programme could spend billions of dollars with very little positive impact on the AIDS MDG or other MDGs.³⁵

Prevention programmes in almost all HIV-affected countries are inadequately funded and implemented. A prevention programme that was started early on in an epidemic and at adequate scale could have a cost per disability adjusted life year (cost/DALY) as low as US\$8,³⁶ which is highly cost effective. Often there are increasing returns to scale in HIV prevention programmes.

If ART is used in addition to an adequate prevention programme, it starts to look much more cost effective under reasonable assumptions – in the range of US\$50-\$500/DALY. There are several key factors.

- Costs of delivering ARVs are falling and will fall into the future, judging by scale economies in the production of other drugs and diagnostics (such as TB).
- AIDS kills productive adults with dependents to a much greater degree than other communicable diseases, except for TB – poverty weighting of benefits or conventional age-weighting of life years saved can at least halve the cost:benefit ratio of ARV treatment (and other AIDS interventions).
- The UK’s advice is to make a strong link between treatment availability and HIV prevention programmes. With assumptions including that treatment availability increases the impact of prevention programmes by between 25 per cent and 50 per cent, then US\$600 per person per year treatment could deliver incremental cost/DALY of US\$100-140.³⁷
- Unquantifiable social capital benefits may be significant in the decision making process if it is thought that ART will prolong life long enough to protect a generation of orphans.
- Unquantified benefits result if quality controlling regulation or quality provision of ART reduces the emergence of drug resistant HIV.
- In middle income countries, treatment substitutes for hospital care as well as keeping people alive, which can cause significant savings³⁸ – much less so in typical low income countries.

The macroeconomic impact of generalised AIDS epidemics is impossible to prove, but is often estimated in the range of 0.5 per cent to 2 per cent reduction in GDP growth.³⁹ If a prevention programme can avert a generalised epidemic, few interventions could claim to have such an impact on GDP. ART which adds substantially to the length of life would have a significant medium term impact on GDP.

Including the considerations mentioned above, the incremental cost/DALY figure for ARV treatment which is good quality and closely linked to HIV prevention programmes is in the US\$50-\$500 range, not the US\$140-\$1200 range – and of course costs are still falling. The lower end of this range approaches ‘cost-effectiveness’ in some low income countries.

Even where ART is cost effective in poor countries, it remains the case that health delivery services need to be significantly strengthened, and a sustainable basis for increased health expenditure needs to be devised if universal access to ART will be achieved over the long run.

WHO and UNAIDS '3 by 5' initiative

The WHO and UNAIDS '3 by 5' target aims to provide ART to 3 million people with HIV and AIDS in developing and transition countries by the end of 2005. The ultimate goal is universal access to HIV and AIDS treatment to all who need it.

At a global level WHO has developed and published a detailed strategic framework for implementation of the '3 by 5' initiative. Actions fall into five key pillars:

- global leadership, strong partnerships and advocacy;
- urgent, sustained country support;
- simplified, standardised tools for delivering antiretroviral therapy;
- effective, reliable supply of medicines and diagnostics; and
- rapidly identifying and reapplying new knowledge and successes.

Activities and milestones have been developed for each of the pillars of the initiative. In line with its mandate and comparative advantage, WHO will focus on technical aspects and standard setting. Simplification and standardisation of treatment is crucial to the scaling up of delivery and WHO is well placed to lead on this. The AIDS Medicines and Diagnostics Service (AMDS) being established will provide countries with support in procurement and distribution of drugs and other commodities. Training will be a key part of the work and WHO will develop standard packages.

The President's Emergency Plan for AIDS Relief

The Emergency Plan for AIDS Relief is a five-year, US\$15 billion initiative. This commitment of resources will help 15 countries in Africa, the Caribbean and Asia. Its targets are to:

- treat 2 million HIV-infected people;
- prevent 7 million new infections (60 per cent of the projected new infections in the target countries); and
- care for 10 million HIV-infected individuals and AIDS orphans.

Key international treatment and care efforts

Implementation of the President's Emergency Plan will be based on a 'network model' being employed in countries such as Uganda, involving a layered network of central medical centres (CMCs) that support satellite centres and mobile units, with varying levels of medical expertise as treatment moves from urban to rural communities. The model will employ uniform prevention, care, and treatment protocols and prepared medication packs for ease of drug administration.

The Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund)

The Global Fund was created to increase resources to fight three of the world's most devastating diseases, and to direct those resources to areas of greatest need. As a partnership between governments, civil society, the private sector and affected communities, the Global Fund represents an innovative approach to international health financing.

The Fund's purpose is to attract, manage and disburse resources to fight AIDS, TB and malaria. It does not implement programmes directly, relying instead on the knowledge of local experts. As a financing mechanism, the Fund works closely with other multilateral and bilateral organisations involved in health and development issues to ensure that newly funded programmes are coordinated with existing ones. In many cases, these partners participate in local country coordinating mechanisms, providing important technical assistance during the development of proposals and implementation of programmes.

The Global Fund is committed to relying on existing financial management, monitoring and reporting systems, where possible.

World Bank

The main approach of the World Bank's portfolio on AIDS in Africa is the Multi-country HIV/AIDS Programme (MAP). The MAP makes available US\$1.0 billion to scale up national AIDS efforts and to support sub-regional AIDS initiatives in Africa. MAP originally comprised of low-interest credits, but now provides funding in the form of grants. These are mostly channelled directly to communities to carry out activities of their own design. The program is available to low-income International Development Association (IDA)-eligible African countries. A parallel program, designed like the MAP, in the amount of US\$150 million, exists to support Caribbean countries.

Eligibility requirements include that MAP countries must have a national AIDS strategy developed in broad partnership with all stakeholders and a high-level national governing body for AIDS with broad stakeholder representation. MAP is intended to be at the heart of government-led processes in each country.

The Treatment Acceleration Programme (TAP) is a sub-regional project being piloted in three African countries (Burkina Faso, Ghana and Mozambique) over a three-year period, to provide care within five integrated treatment components.

William J Clinton Foundation HIV/AIDS Initiative

The Clinton Foundation HIV/AIDS Initiative aims to assist nations in implementing large-scale integrated care, treatment and prevention programmes in their countries. It partners with countries in Africa and the Caribbean.

The foundation recently announced a partnership with the Global Fund, the World Bank and UNICEF to make it possible for developing countries to purchase medicines and diagnostics at low prices.

The foundation has brokered an agreement with four Indian generics companies – Cipla, Ranbaxy, Hetero and Matrix – as well as Aspen, a South African company, to offer the most common first line formulation for as low as US\$140 per person a year.

Diagnostic tests are available from five companies, including CD4 tests from Beckman Coulter and Beckton Dickinson, and viral load tests from Bayer Diagnostics, bioMerieux and Roche Diagnostics.

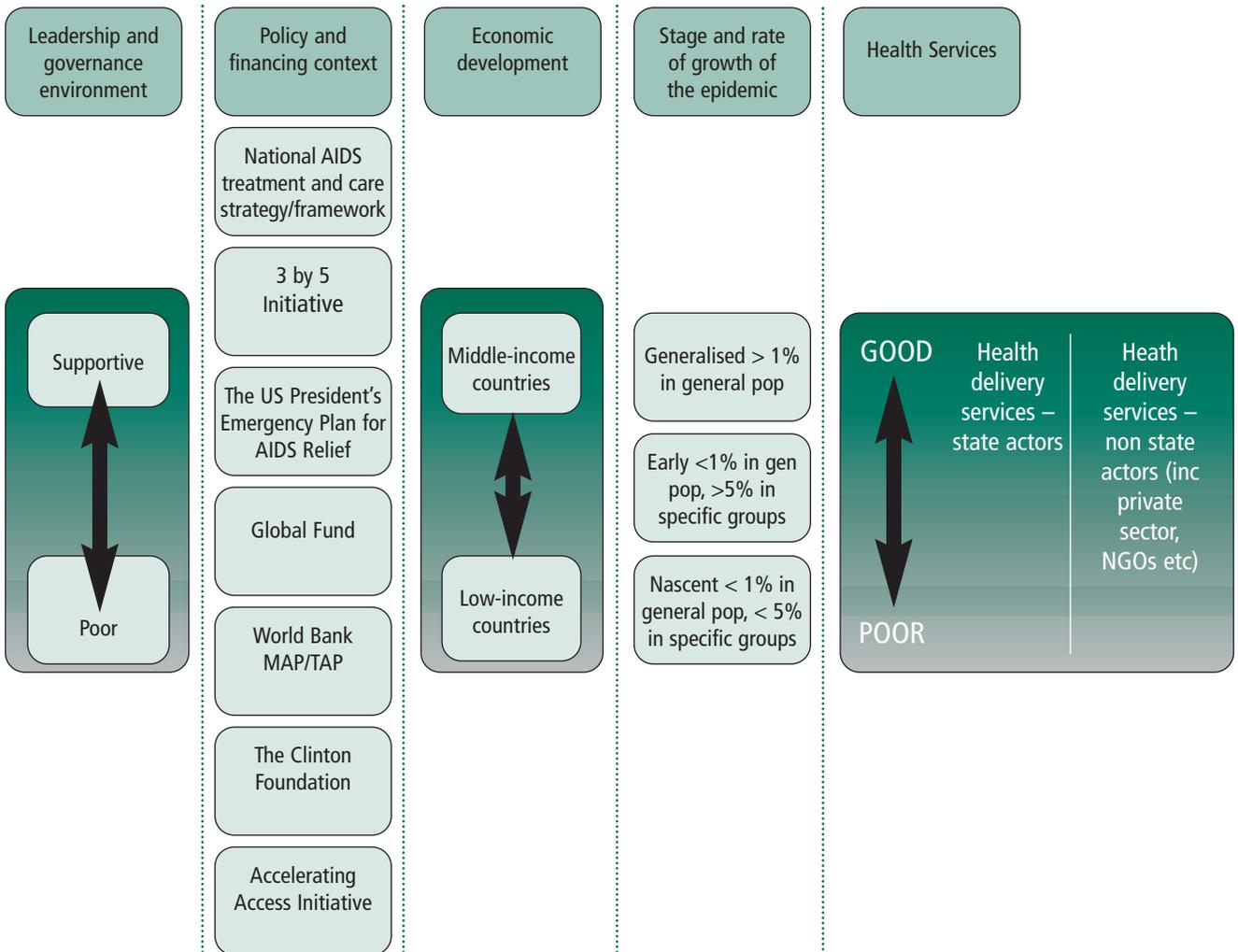
Accelerating Access Initiative

The Accelerating Access Initiative (AAI) was established in May 2000 to help increase access to HIV and AIDS care and treatment in developing countries. AAI is a cooperative partnership between UNAIDS, WHO, UNICEF, the UN Population Fund (UNFPA), the World Bank and six research-based pharmaceutical companies: GlaxoSmithKline (GSK), Boehringer Ingelheim, Merck & Co, Abbott Laboratories, Bristol Myers Squibb and F Hoffman – La Roche.

The initiative aims to improve access to more affordable HIV-related medicines and diagnostics for least developed countries and those hardest hit by the epidemic, in the context of a broader framework of care, treatment and support.

Summary diagram of main factors in UK decision-making

Country context : factors affecting the 'shape' of HIV and AIDS treatment and care responses



Summary diagram

Strategies for UK support to country programmes should be built on an assessment of the **country context**, including identifying local needs, issues and existing service provision. The **elements of an effective response** should be used as a guide – alongside the **principles underpinning the UK's response** – to inform the phased introduction of treatment and care to move towards comprehensive programmes.

Policy options: Interventions and principles

Community preparedness

People with HIV, community mobilisation, local groups, activists, community groups etc.

Elements of an effective response

Deepening the response

- Education and prevention
- HIV counselling and testing with informed consent, in health facilities and in services targeting vulnerable and difficult to reach populations
- Community mobilisation
- Support for positive living, including social protection, nutrition, welfare and psycho-social support
- Programmes to address stigma and discrimination
- Psycho-social care and peer support
- Palliative and home-based care
- Prevention and treatment of opportunistic infections and sexually transmitted infections
- Prevention of mother-to-child transmission plus (PMTCT+).
- Human resources management, including training and quality assurance
- Treatment literacy
- Antiretroviral therapy and monitoring, including essential laboratory and clinical back-up, and systems for drug management
- Adherence support
- Bereavement support
- Operational research

Widening the response

- Prioritising marginalised and vulnerable groups

Strengthening the response

- Health Services
- Private sector, trade unions, NGOs and community groups, including people with HIV and AIDS
- Demand creation and tackling stigma and discrimination
- Research

Principles underpinning the UK's response

- Treatment and care programmes should be pro-poor, gender, child and equity focused, and should prioritise the access of the poorest and most vulnerable.
- People affected by HIV and AIDS – especially poor people and women – should be involved in decision making about national treatment and care programmes.
- Programmes should support sustainable health services, and long term HIV prevention and impact mitigation efforts.
- Programmes should ensure that international and national efforts support country-led programmes.
- Programmes should be informed by evidence, and should be ambitious in desired effect on health and development.

References

- ¹ UNAIDS, 'Report on the Global AIDS Epidemic: 4th global report', July 2004, pp. 190 – 193.
- ² Ibid p 102.
- ³ see Annex 2.
- ⁴ Attawell K and Mundy J, 'Provision of antiretroviral therapy in resource-limited settings: a review of experience up to August 2003', WHO and DFID, November 2003 (www.who.int/3by5/publications/documents/en/ARTpaper_DFIGD_WHO.pdf).
- ⁵ The cost of antiretroviral drugs has fallen significantly, in some cases by up to 95 per cent in the last three years. See WHO, '25 Years of Essential Medicines 1977-2002', 2002; MSF, 'Untangling the web of price reductions: a pricing guide for the purchase of ARVs for developing countries', 4th edition 2003.
- ⁶ The MDGs set targets for reducing poverty, hunger, disease, illiteracy, environmental degradation, and discrimination against women by 2015 as well as for combatting HIV and AIDS (www.un.org/millenniumgoals/).
- ⁷ Global HIV Prevention Working Group, 'HIV Prevention in the Era of Expanded Treatment Access', June 2004, pp 6-7.
- ⁸ World Health Organisation, 2003, 'Emergency scale-up of antiretroviral therapy in resource limited settings – technical and operational recommendations to achieve 3 by 5', report of the WHO/UNAIDS International Consensus Meeting on Technical and Operational Recommendations for Emergency Scaling-Up of Antiretroviral Therapy in Resource-Limited Settings, 18-21 November 2003, Lusaka, Zambia, pp 18-19.
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Tel: +44 (0) 20 7023 0000

Fax: +44 (0) 20 7023 0016

Website: www.dfid.gov.uk

E-mail: enquiry@dfid.gov.uk

Public Enquiry Point: 0845 300 4100 or +44 1355 84 3132 (if you are calling from abroad)

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