

## Progress in countries

For highly affected countries, response to the global health emergency has been a joint project of governments, civil society and the private sector. Courageous effort has led in several instances to remarkable progress, often in very difficult fiscal, political and social circumstances. A significant proportion of the funding for scale-up has come from countries themselves, despite a host of competing and urgent priorities. National AIDS councils and other coordinating bodies have developed rapidly in recent months, in some cases almost from the ground up. Many countries have set specific numerical targets for people on ARV therapy by the end of 2005.

### Botswana: political leadership shows the way

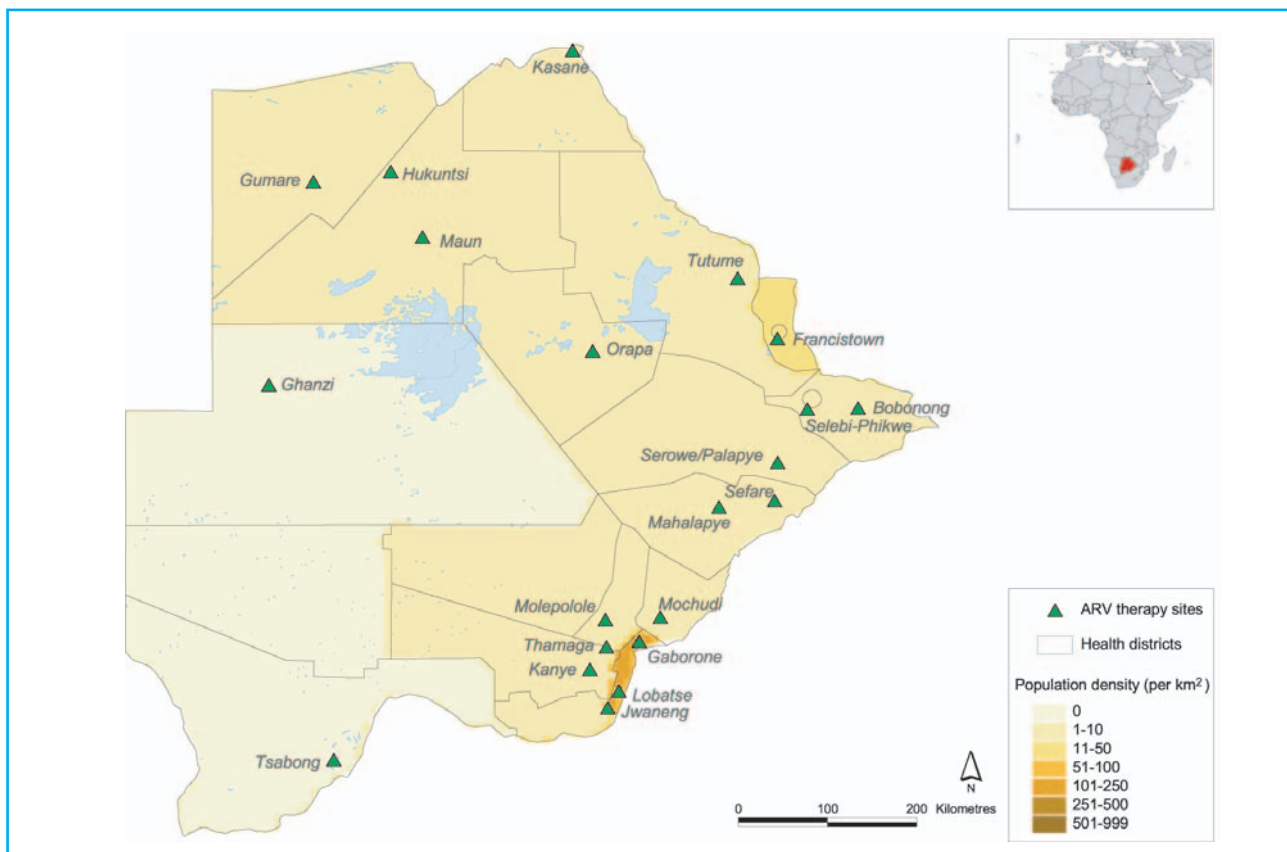
In Botswana, where one in three pregnant women tests HIV positive, political leadership and public-private partnerships are making a significant difference.

Faced with the second highest HIV prevalence in the world, the Government of Botswana has made HIV/AIDS a priority and has adopted a compelling, long-term vision to have no new HIV infections by 2016, when Botswana will celebrate 50 years of independence.

One of the first steps was creating a public-private partnership, the African Comprehensive HIV/AIDS Partnerships, with the Bill & Melinda Gates Foundation, The Merck Company Foundation and the pharmaceutical company Merck & Co., Inc.

ARV therapy programmes were first implemented in January 2002 with the Princess Marina Referral Hospital in the capital, Gaborone. Twelve facilities were offering ARV therapy by 2003 and 23 sites in 2004, covering all but two districts (Fig. 5). The programme is also being extended from hospitals to clinics.

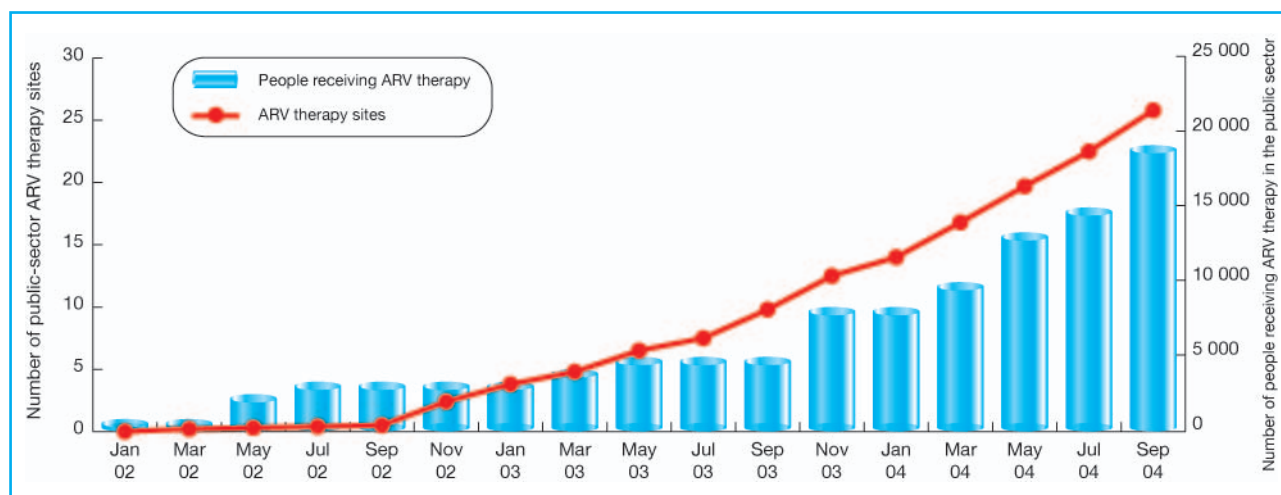
**Fig. 5. Location of sites providing ARV therapy in Botswana, September 2004**



By March 2004, 2212 health workers had been trained including physicians, nurses, pharmacists, counsellors and other health workers. Of these, 536 were recruited specifically to support ARV therapy and to implement programmes for preventing mother-to-child transmission of HIV.

The number of adults receiving treatment in Botswana rose gradually during the first years of the public-private partnership and much more rapidly in 2004. About one quarter receive treatment through private facilities. In the public sector (Fig. 6), ARV therapy is provided free of charge to citizens of Botswana. Adherence in terms of self-reporting, pill counts and attending scheduled appointments is good (85%) and is confirmed by complete viral load suppression every six months.

**Fig. 6. Number of public-sector ARV therapy sites and number of people receiving ARV therapy in the public sector in Botswana, 2002–2004**



A social mobilization campaign designed to increase public awareness of the availability and outcomes of ARV therapy has helped to reduce stigma and increased the involvement of people living with HIV/AIDS in promoting a supportive environment. A comprehensive approach to the entire family of the person initially diagnosed substantially increases public awareness and support for the programme. A routine offer of HIV testing was introduced in hospitals in January 2004.<sup>10</sup> Pregnant women are told that HIV tests are standard and are asked whether they want to opt out – an approach often used for other standard medical tests. During the first four months, 18 hospitals offered HIV testing to 6384 people, of whom one in seven opted out.

<sup>10</sup> Seipone K et al. Introduction of routine HIV testing in prenatal care, Botswana 2004. *MMWR*, 2004, 53:1083–1086.

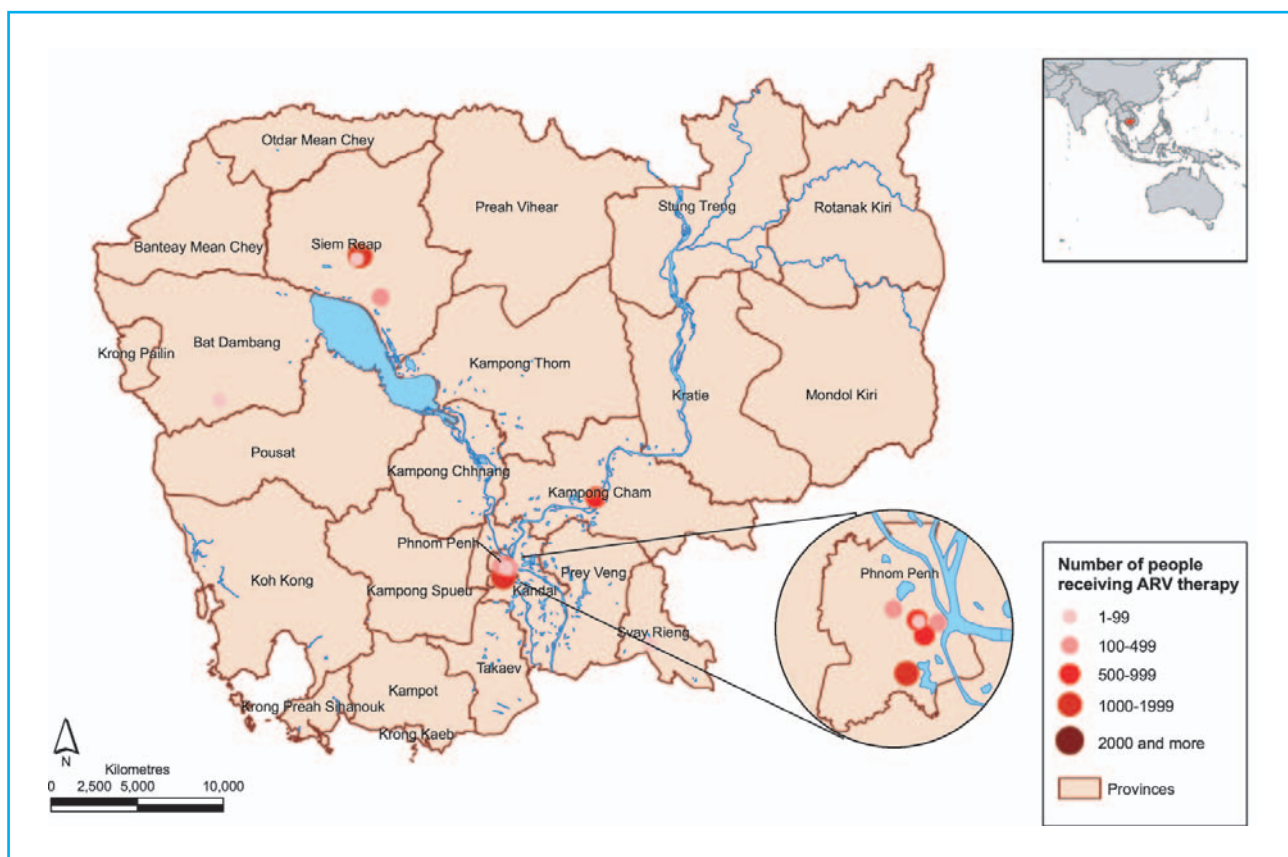
### Cambodia: coordination at the country level

At the end of 2002, access to comprehensive HIV care and support services was limited, concentrated in urban areas and almost entirely supported by international nongovernmental organizations. Availability of treatment for opportunistic infections and ARV therapy was limited to three hospitals in the capital, Phnom Penh, and the major provincial city of Siem Reap.

Significant progress has been made in the past two years. The National Center for HIV/AIDS, Dermatology and Sexually Transmitted Infections of the Ministry of Health has successfully established a broad partnership around a national framework for prevention and care that includes increasing access to ARV therapy and focuses on decentralizing services to districts beyond the main cities.

By the end of 2004, 75 accredited sites were offering testing and counselling. These included 61 supported directly by government, 13 by nongovernmental organizations and one private centre established in Phnom Penh. Care services, including access to ARV drugs, are currently being expanded to seven sites in Phnom Penh and a further seven sites in other districts. At the end of October 2004, 4527 people were receiving ARV therapy (Fig. 7). This corresponds to about one in five adults who need treatment. About 7% of those receiving treatment were children.

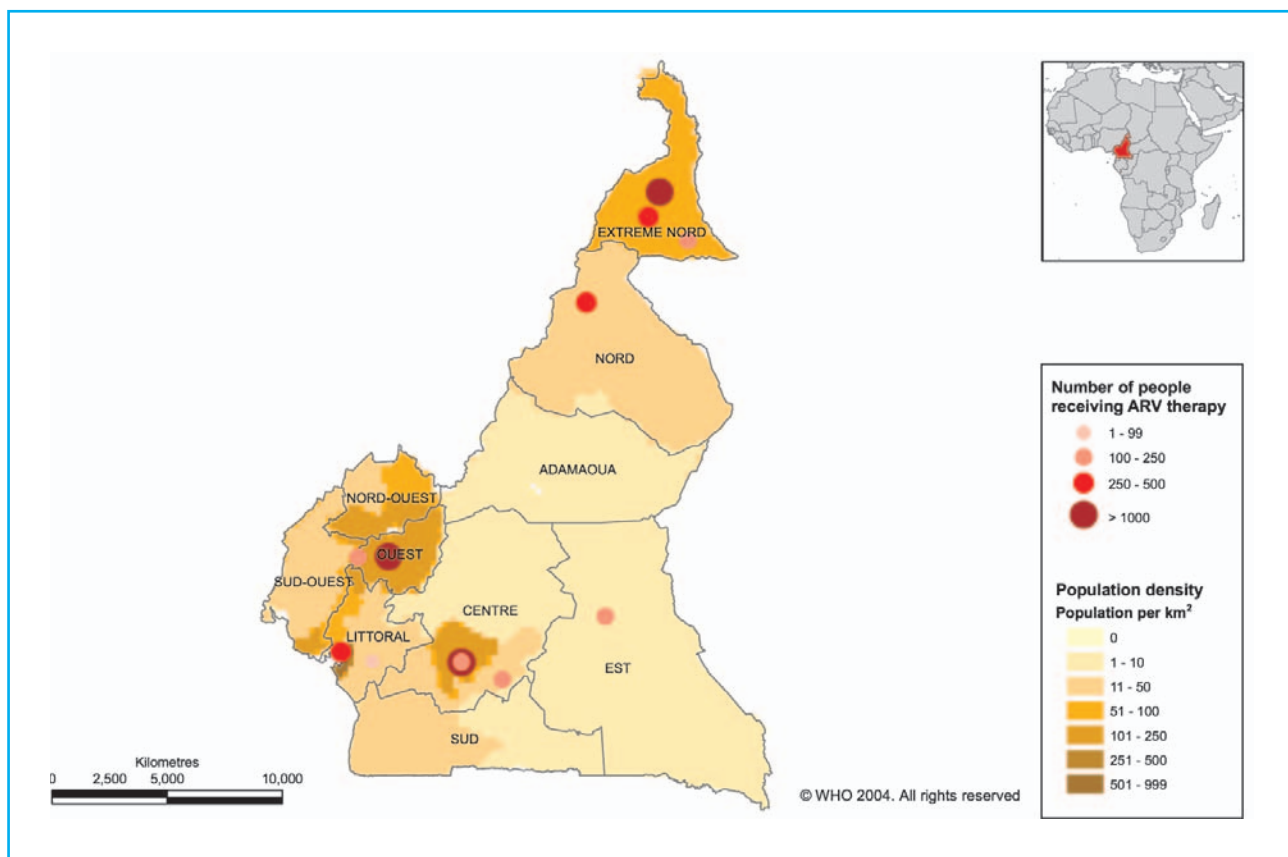
**Fig. 7. Number of people receiving ARV therapy at 14 sites in Cambodia, December 2004**



## Cameroon: rolling out testing and counselling

As of 2003, UNAIDS and WHO estimated that 560 000 people in Cameroon were living with HIV/AIDS, which accounts for about 49 000 annual deaths. Cameroon has set a national target of providing ARV therapy to 36 000 people living with HIV/AIDS by the end of 2005. By November 2004, more than 12 000 people were receiving treatment (Fig. 8). Strong political commitment over the past five years and a dramatic decrease in cost from US\$ 600 to US\$ 30 per month of treatment in four years have been the indispensable prerequisites for scale-up. Counselling has also become less costly, and more people are requesting HIV testing. Provincial centres now assess eligibility for treatment at entry points such as the 14 voluntary counselling and prevention centres, 160 sites for preventing mother-to-child HIV transmission, 21 certified treatment centres and 140 tuberculosis screening centres.

**Fig. 8.** Number of people receiving ARV therapy at 21 sites in Cameroon, October 2004



## Haiti: Global Fund helping to turn the tide

Haiti is the poorest country in the Americas and also, not coincidentally, the country most burdened by HIV. Political strife and natural disasters have also made work in Haiti extremely difficult in 2004. Nevertheless, remarkable strides have been made in the struggle against AIDS, and one reason is that Haiti was one of the first countries to receive funding from the Global Fund to Fight Aids, Tuberculosis and Malaria. Haiti was able to respond quickly to the first funding round because of a broad-based country coordinating mechanism under the activist leadership of former First Lady Mildred Trouillot Aristide, who had also led the Haitian delegation to the United Nations General Assembly Special Session on HIV/AIDS in 2001. A broad range of missions working to improve health in Haiti offered technical assistance. A group of AIDS-focused nongovernmental organizations worked with both officials of the Ministry of Health and groups of people living with HIV/AIDS to propose an integrated prevention-and-care model that also stressed the importance of community-based efforts in both rural and urban Haiti.

One of the chief challenges for many of those implementing the projects are low rates of literacy and numeracy, especially in rural Haiti. The Global Fund proved responsive to requests for simplified reporting, and the Global Fund's local fund agents also provided technical assistance in accounting and reporting. The Global Fund provided the first large grants that many smaller organizations had received. Nevertheless, with broad technical assistance and the hard work of those on the front lines of prevention and care, Haiti was among the countries meeting or exceeding all the goals of the initial proposal.

The Global Fund also provided Haiti with its first substantial funding for care for people living with advanced HIV disease. Tens of thousands sought voluntary counselling and testing. Support from the President's Emergency Plan for AIDS Relief, working closely with the Global Fund, between February and September 2004 provided ARV therapy to 2800 people in urban and central Haiti. The advent of proper AIDS care has led to a sustained interest in voluntary counselling and testing, which has also provided new opportunities for both primary and secondary prevention. The safety of transfusion has improved, with at least one new blood bank established in central Haiti under the auspices of the Haitian Red Cross.

These successes are due in great part to the ability of the Global Fund to respond quickly and flexibly to the great need registered in poor countries, which are also those that often have inadequate infrastructure for managing and reporting. Global Fund experience in Haiti suggests that improving such capacity should be a part of projects rather than a reason to avoid funding small and administratively weak organizations in areas without electricity, adequate roads or land telephone lines.

## Mozambique: first steps towards an ambitious goal

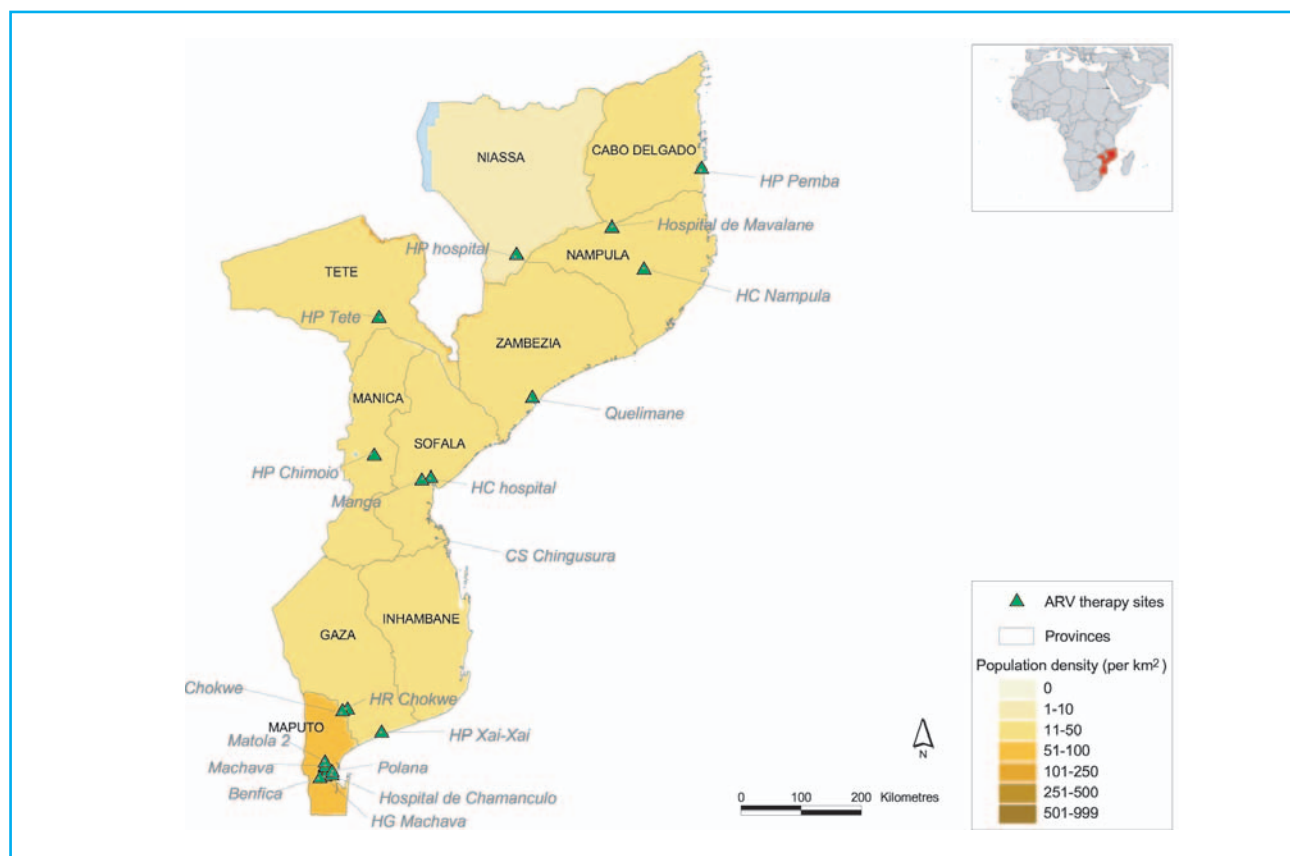
Ravaged by decades of civil war, a slowly recovering Mozambique is another example of what can be achieved in extremely difficult circumstances.

With about 200 000 adults needing ARV therapy, the country's major challenges include a scarcity of resources, shortages of trained health care workers and poor coordination among several partners working in the country. Nevertheless, there is strong political commitment, and the National Health Sector Strategic Plan to Combat Sexually Transmitted Infections and HIV/AIDS calls for scaling up ARV therapy to 132 000 people by the end of 2008.

Mozambique has a specific plan to train 2000 intermediate-level health care professionals, and a new drug management and logistics system is being developed in anticipation of a massive increase in ARV therapy coverage.

Given the scale of the challenges, the increased availability of ARV therapy during 2004 is encouraging, with the Ministry of Health reporting almost 6300 people receiving treatment in November 2004 versus 2800 in June 2004. Twenty-three sites offer ARV therapy in the public sector through collaboration between the government and nongovernmental organizations such as the Community of Sant'Egidio, MSF and Health Alliance International (Fig. 9).

**Fig. 9.** Location of sites providing ARV therapy in Mozambique, October 2004



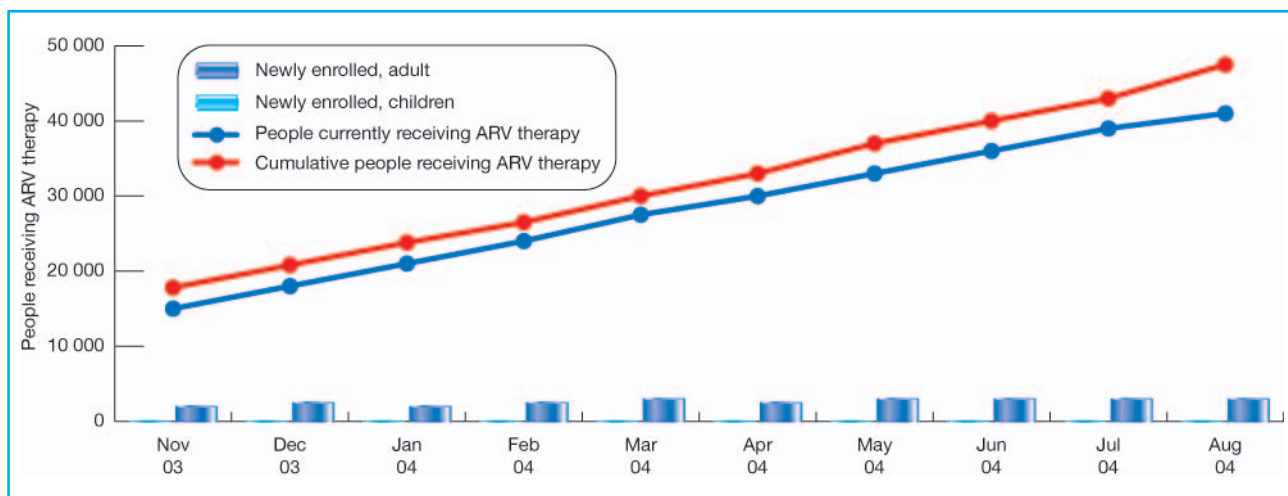
### Thailand: rolling out in all districts

In 2003, UNAIDS and WHO estimated the number of people living with HIV/AIDS in Thailand to be 570 000 and that 58 000 deaths were related to AIDS. The national ARV therapy programme includes extensive training of health personnel, a standardized national ARV therapy protocol, a computerized central procurement and supply system with regional centres, the formation of a laboratory network and a well-functioning monitoring and evaluation system. An electronic system for data transmission is being put in place. The Government of Thailand increased its budget for ARV therapy from 300 million baht (US\$ 7.7 million) in 2003 to 800 million baht (US\$ 20.5 million) in 2004.

The programme was rolled out from specialist centres to 914 hospitals in three years. Patient groups and nongovernmental organizations have been working to provide people living with HIV/AIDS with enough knowledge to make informed decisions on treatment and to play a central role as partners in providing care.<sup>11</sup> The number of people receiving ARV therapy has been increasing linearly, with more than 3000 new adults and an additional 200–300 children enrolled every month between January and August 2004 (Fig. 10). Since there were 40 000 people on treatment in August 2004, Thailand is projected to have reached more than 50 000 by the end of 2004.

Thailand has also made a major effort to enhance prevention and treatment of opportunistic infections, including co-trimoxazole prophylaxis, the treatment of TB and secondary prophylaxis for cryptococcal meningitis among people living with HIV/AIDS.

**Fig. 10.** Enrolment in ARV therapy programmes in Thailand, November 2003–August 2004



<sup>11</sup> Kumphitak A et al. *Involvement of people living with HIV/AIDS in treatment preparedness in Thailand*. Geneva, World Health Organization, 2004 ([http://www.who.int/hiv/pub/prev\\_care/thailand/en](http://www.who.int/hiv/pub/prev_care/thailand/en), accessed 31 December 2004).

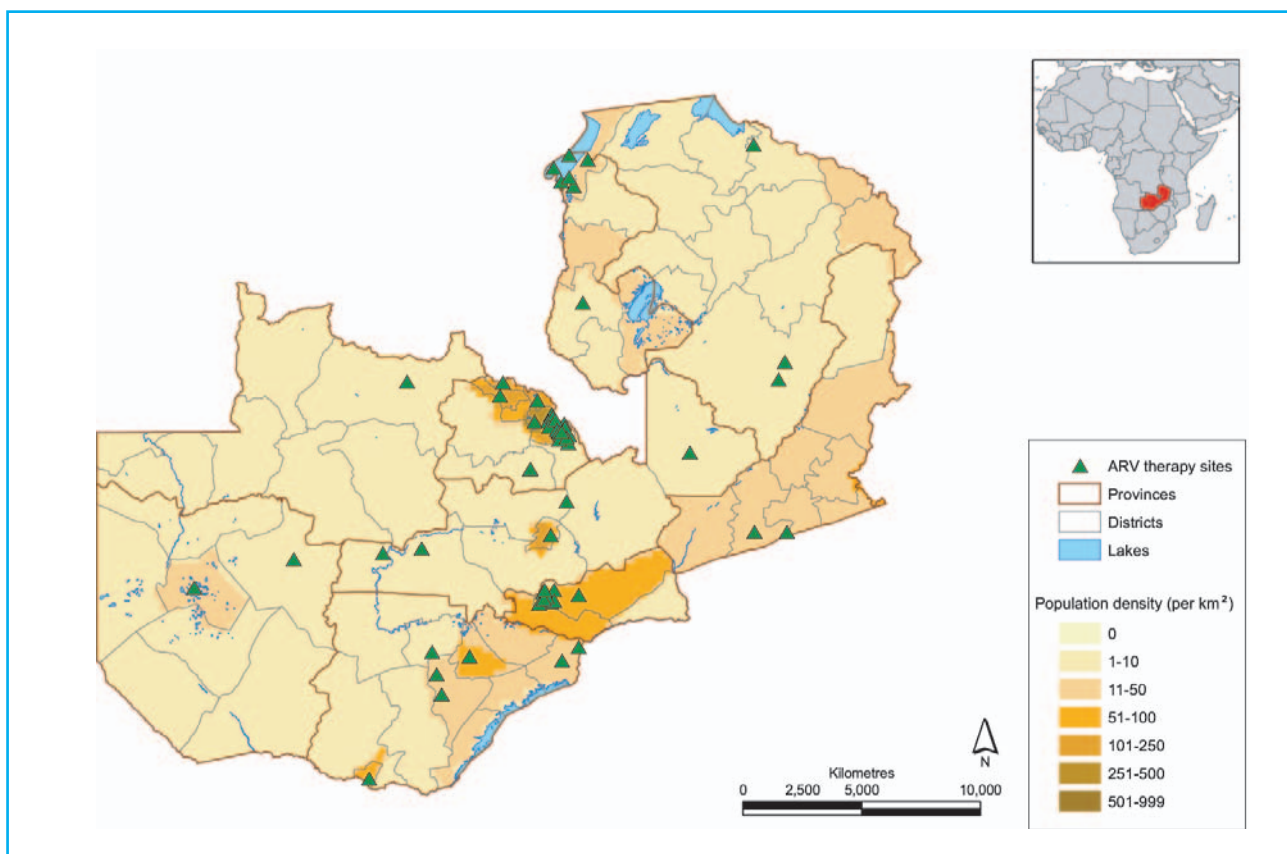
## Zambia: a rapidly expanding programme

With a national HIV prevalence of 15% and growing numbers of people with advanced HIV infection, the demand for treatment and care in Zambia increased rapidly during the 1990s. Until November 2002, a single drug through the private sector was the only available treatment. In January 2003, the government decided to purchase sufficient drugs to treat 10 000 people but within a year its target increased to 100 000, which is well over 50% of the estimated number of people needing ARV therapy.

The public sector began providing ARV therapy with two pilot sites at the University Teaching Hospital Lusaka and at Ndola Central Hospital. The second phase extended to the remaining seven provincial hospitals plus Kitwe Central Hospital. The final phase involved roll-out at the district level. By the end of 2004, ARV therapy was available at 53 centres (Fig. 11). Twenty-four of 72 districts had at least one site offering ARV therapy and 11 districts had two or more sites. The distribution of sites closely mirrors Zambia's population distribution, with most sites concentrated in Lusaka and in the Copperbelt.

By September 2004, more than 11 000 people were receiving ARV therapy through the public sector versus just over 7000 in July, an increase of 57% in less than three months. The government decision to make ARV therapy free of charge is likely to have played a major role in this rapid increase. An additional 2400 people receive ARV therapy through the private sector, mainly through the mining industry. The increase in provision of ARV therapy to children has been equally rapid, although children on treatment still accounted for only 2.6% of all those receiving treatment.

**Fig. 11.** Location of sites providing ARV therapy in Zambia, November 2004



## Sharing the task

During 2004, the mobilization around the “3 by 5” target has grown into a mature partnership. At least 136 partners are formally involved as advocates, donors, advisers, collaborators and providers of funding and technical and other services (Table 2). As relationships continue to evolve, new synergies develop, and each new partner brings skills and networks that greatly enhance the scope of “3 by 5”. Further, these partners extend and deepen their relationships beyond the early discussions. Although the partnership focuses especially on scaling up treatment, it also addresses key issues such as equity, prevention and health systems.

**Table 2. Nature and focus of the 136 partners of the “3 by 5” Initiative**

Nature of partnership <sup>a</sup>		Focus of partnership <sup>a</sup>	
Technical	86	ARV therapy	69
Collaborative	54	Advocacy	63
Networking	32	Prevention	27
Financial	14	Donors	22
Political	8	Voluntary counselling and testing	21
		Preventing mother-to-child transmission	17
		Procurement	11

<sup>a</sup> Each partner could choose multiple partners.

### Partnership highlights

Highly affected countries are the fulcrum of “3 by 5” partnership activities. In recent months, governments have devoted unprecedented time, energy and money to combating the pandemic, visible not only in the expansion of infrastructure at the local and district level, but also in coordination and planning through national HIV/AIDS programmes. Community-based organizations and nongovernmental organizations have been at the forefront of providing prevention, care and treatment services (Box 2). Some nongovernmental organizations support large numbers of people on treatment in multiple countries. For instance, MSF reported 23 000 people receiving treatment in 27 countries by September 2004.

Most business leaders in severely affected countries expect AIDS to seriously affect future business. Mining companies such as Anglo American (aiming to have 3000 people receiving ARV therapy in 2004) and a handful of other multinational companies have taken responsibility for treating and preventing AIDS among their own employees in Asia and Africa. In most instances, treatment programmes are still small, the uptake of counselling and testing has been modest and stigma and discrimination are still major stumbling blocks. The Global Business Coalition on HIV/AIDS, dedicated to combating the AIDS epidemic through the business sector’s unique skills and expertise, has expanded its membership to more than 170 international companies.

## Box 2. Community-based organizations show the way

A survey of community-based organizations in early 2004 by SIDACTION provides many examples of the pivotal role they play in HIV/AIDS treatment and care in Africa.<sup>12</sup>

In Burkina Faso, two organizations began importing generic drugs before anyone else. The Oasis Centre, opened by Association African Solidarité in 1998 in Ouagadougou, has been supplied with generic ARV drugs through the financial support of European nongovernmental organizations. More than 100 people, who contribute through a community trust, have been receiving treatment. The Centre supplies many other care and support services to families affected by HIV/AIDS.

In Burundi, most people receive ARV drugs through community-based organizations. This is chiefly implemented through the Association Nationale de Soutien aux Séropositifs et Sidéens (ANSS), the main organization for people living with HIV/AIDS. In 2003, ANSS provided medical follow-up for 1700 people, including 1000 people receiving ARV therapy. It provides comprehensive care and is the largest service provider in Burundi.

In Mali, ARV drugs were brought into the country long before any government programme, and people receiving ARV therapy and health professionals have since lobbied for increased access. Three years ago, Espoir Vie-Togo was a “small support group”. Today there are 100 clients, with 70 taking ARV drugs.

The efforts of the Treatment Access Campaign in South Africa to lobby for access to treatment and bring about political changes are well known. Today, there are similar organizations in such countries as Burkina Faso, Kenya and Nigeria. African AIDS activism is now a reality.

The Partnership for Access to Antiretrovirals (PAARV) was launched in 2002 for a number of African community-based organizations financially supported by SIDACTION. The programme facilitates access to ARV drugs for the organizations’ staff, which includes active volunteers, elected representatives and salaried staff. In other words, these are the people that keep the organization up and running. By September 2004, PAARV was active in eight African countries.

Since the “3 by 5” strategy was released in December 2003, international commitment to scaling up HIV treatment, care and prevention has dramatically increased (Annex 3). The entire UNAIDS Secretariat and the 10 UNAIDS Cosponsors have participated in promoting this encouraging development. For its part, WHO substantially altered its staffing patterns to support “3 by 5,” relocating a number of technical positions from Geneva to highly affected countries. WHO is also providing leadership in developing normative standards and guidelines and operational research related to scaling up ARV therapy and accelerating prevention efforts. WHO has taken a lead role in developing and adapting training modules suitable for implementation in underserved locations.

The UNAIDS Secretariat has made significant contributions to overall leadership and advocacy of global efforts to combat HIV/AIDS, directing harmonization of policies and guidelines and directly supporting countries and regional structures to build critical capacity. The nine other UNAIDS Cosponsors have increasingly incorporated “3 by 5” into their respective areas of work.

In recent months, the World Bank has stepped up its already substantial investment for HIV/AIDS programmes by providing financial and technical support for improving national health systems in 100 countries. It has also provided direct support to ARV therapy programmes in the Caribbean, 13 African countries, three Asian countries and one country in eastern Europe, and it has announced the Treatment Acceleration Project in three African countries.

By December 2004, the Global Fund to Fight AIDS, Tuberculosis and Malaria had received pledges for US\$ 5.9 billion and payments of US\$ 3.3 billion against those pledges. In four rounds, it had approved proposals with a two-year value of US\$ 3.1 billion and disbursed US\$ 860 million. With these four first rounds, the Global Fund is projected to reach 52 million people with voluntary counselling and testing for HIV and 1.6 million people with ARV therapy over the five-year lifetime of the individual grants.

<sup>12</sup> de Cenival M, Prunier-Duparge C. *Accès commun*. Paris, SIDACTION, 2004 ([http://www.sidaction.org/accescommun/index\\_en.php](http://www.sidaction.org/accescommun/index_en.php), accessed 31 December 2004).

Since its establishment in 2003, the United States President’s Emergency Plan for AIDS Relief has created an unprecedented dynamic, making a major contribution to scaling up responses to HIV/AIDS with a 5-year commitment of \$15 billion and a mission to treat 2 million people, prevent 7 million new infections, and provide care and support to 10 million people infected and affected by HIV/AIDS, including orphans and vulnerable children. Beginning in 2004, the United States President’s Emergency Plan for AIDS Relief spent US\$ 2.4 billion on AIDS worldwide. The 2005 budget requests US\$ 2.8 billion for AIDS globally, which more than triples the investment since 2001.

A number of other bilateral donors have made critical contributions to the “3 by 5” effort. The Government of Canada, for example, underwrote much of the recent expansion of WHO activity at the country level. Canada’s contribution to support efforts related to “3 by 5” was the largest single donation to WHO in its history. The Government of the United Kingdom, UNAIDS and the World Bank have also strongly supported technical and operational support to countries, as have Sweden, Italy, Norway, Belgium, Spain, Luxembourg and the OPEC Fund for International Development. More than two thirds of the resources for “3 by 5” will go directly to WHO country offices, which are being strengthened to offer technical support for country efforts. Progress towards the “3 by 5” milestones is summarized in Annex 4.

With the encouraging increase in attention to HIV came several new challenges, including the emergence of multiple coordinating mechanisms and initiatives with multiple procedures and requirements for funding, monitoring and reporting at the country and programme level. Harmonizing efforts within the HIV/AIDS response community is ever more essential.

Recognizing the new contours of the playing field, activists, providers, officials and people living with HIV/AIDS in affected countries, along with donors and stakeholders, have developed a series of principles known as the “three ones”. The principles are **one** agreed HIV/AIDS action framework that drives the alignment of all partners, **one** national HIV/AIDS coordinating authority with a broadly based multisectoral mandate and **one** agreed HIV/AIDS monitoring and evaluation system at the country level. The “three ones” concept for country-level responses to HIV/AIDS provides a framework for ensuring that resources and effort are harmonized, sustainable and based on results. Monitoring and Evaluation (M&E) has been simplified and harmonized by all major partners agreeing on common reporting frameworks, like the joint partner M&E toolkit. This toolkit has already been successful in harmonizing and simplifying M&E and reporting back to donors, providing a basis to support common global estimates in this report.