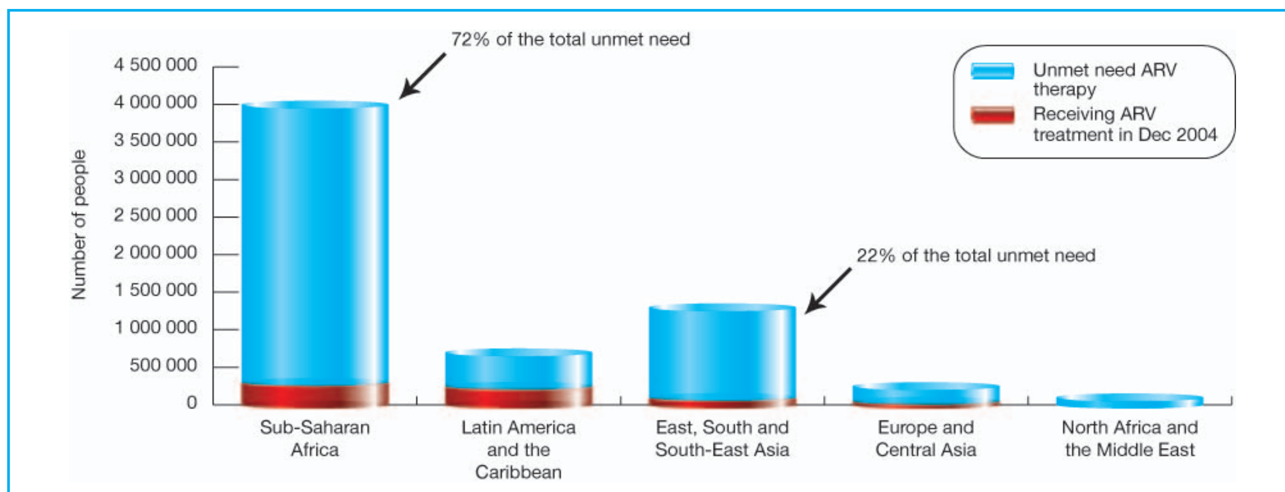
The way forward: challenges in 2005

Progress in 2004 has laid the foundation for the extraordinary effort needed to reach the "3 by 5" target by the end of 2005. Many countries need to accelerate their scale-up, and commit additional resources. International organizations need to become much faster in providing assistance. The second half of 2004 saw tremendous shifts, as political will translated into action. Although the level of commitment is encouraging, it must accelerate in 2005. Necessary innovations such as the routine offer of testing and counselling in many key health care settings and reducing or abolishing user fees at the point of service require significant energy and focus by providers, policy-makers and communities; meanwhile, policy changes by national governments, bilateral and multilateral funders and other stakeholders continue to be critical to maximize the funds available for scaling up treatment.

Growing demand for treatment

Reaching the target of 3 million people by the end of 2005 requires having at least another 2.3 million people initiate treatment. A total of 5.1 million adults still need treatment in 2005 and are not receiving it; 72% live in sub-Saharan Africa and 22% in Asia. These two regions thus account for nine of ten people whose need for treatment has not yet been met (Fig. 17).

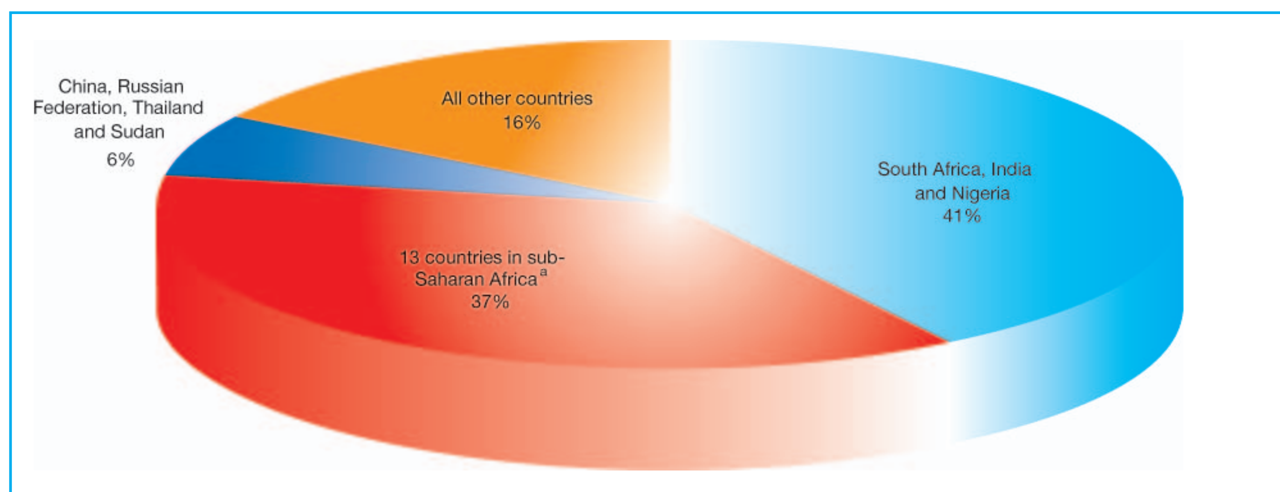
Fig. 17. **Unmet need for ARV therapy among adults in developing and transitional countries in 2005**



Twenty countries have at least 50 000 people each who still need treatment in addition to the people who are already on treatment (unmet need). Together these countries represent 84% of the unmet need for ARV therapy in developing and transitional countries in 2005 (Fig. 18). The top three, South Africa, India and Nigeria, account for 41% of the need. Thirteen countries in sub-Saharan Africa – Zimbabwe, United Republic of Tanzania, Ethiopia, Mozambique, Kenya, Democratic Republic of the Congo, Malawi, Zambia, Cameroon, Côte d'Ivoire, Uganda, Lesotho and Ghana – have 37% of the 5.1 million people who still need to initiate treatment. China, the Russian Federation, Thailand and Sudan add another 6%.

The figures speak for themselves. Global progress towards the "3 by 5" target can only be made if major progress is made in the countries with the greatest unmet need for treatment.

Fig. 18. Where do the 5.1 million people who need to start treatment in 2005 live?



[a] Other than South-Africa and Nigeria.

The resource gap

As of mid-2004, the costs of achieving "3 by 5" were estimated to be US$ 3.1 billion to US$ 3.8 billion for 2005 depending on drug costs and the rate of programme expansion in 2004.[23] ARV drug costs accounted for 43% of this amount in one of the higher drug cost scenarios.

More recently, using the Zambia treatment model with an average drug cost of US$ 304 per person per year as a standard and applying it to 49 high burden and focus countries, it has been estimated that, to achieve "3 by 5", US$ 3.55 billion to US$ 3.80 billion is needed in 2005.[24] Based on commitments and pledges, about $1.55 billion is available for 2005 from developing and transitional country sources, Global Fund to Fight AIDS, Tuberculosis and Malaria disbursements to countries, the United States President's Emergency Plan for AIDS Relief, World Bank and other donors. This would leave a shortfall of more than $2 billion. The resource gap can be reduced by reductions in the costs of drugs or service delivery.

Clearly, the equation still does not balance. The level of international commitment to the "3 by 5" target must be matched by action on the ground. This will require, over the next 12 months, a concerted, collaborative effort to speed up the rate of disbursement and coordination between funders, country officials and providers to ensure that funds are swiftly absorbed and to ensure that oversight and urgent scale-up are complementary aims. Countries can also commit additional resources and make more effective use of new and existing health personnel.

Ensuring equitable access

Access to ARV therapy services will need to be improved dramatically by increasing the numbers and distribution of service delivery points, especially in rural populations. More people need to come forward for testing and counselling. Stigma and discrimination issues will have to be addressed aggressively.

Strong uptake and reporting from programmes designed to prevent the mother-to-child transmission of HIV indicate that more women are receiving treatment in public facilities than men. This development, however, needs to be monitored closely. It is critical that testing, prevention and treatment access for children be improved, an effort that will include, among other things, widespread availability of affordable pediatric ARV formulations. Further, equitable access must be ensured for marginalized populations most affected by the epidemic such as prisoners, sex workers, injecting drug users and men who have sex with men. Drugs and diagnostics must become affordable for everyone in need.

23 Gutierrez JP et al. Achieving the WHO/UNAIDS antiretroviral treatment 3 by 5 goal: what will it cost? *Lancet*, 2004, 364: 63–64. *Estimating funding gap to reach the target of 3 million with access to antiretroviral drugs by 2005 ("3 by 5")*. Geneva, World Health Organization, Department of HIV/AIDS, unpublished document.

24 *Estimating funding gap to reach the target of 3 million with access to antiretroviral drugs by 2005 ("3 by 5").* Geneva, World Health Organization, Department of HIV/AIDS, 2004, unpublished document.

Efficient and effective treatment programmes

As HIV/AIDS evolves from a death sentence to a chronic disease, much needs to be done to further develop high-quality ARV therapy programmes. This includes management teams to coordinate the process of providing services, treatment preparedness and community engagement, reliable and efficient procurement and supply chains, training and capacity-building, standardized systems for monitoring the adherence of people receiving ARV therapy and treatment success, monitoring drug resistance, adherence support and operational research to learn by doing. Greater links between HIV and TB treatment and prevention programmes will greatly increase the scale-up of both services.

Prevention – full speed ahead!

Treatment provides an opportunity to strengthen prevention, but investment in prevention is needed more than ever to turn around the epidemic. Salomon et al.[25] modelled the epidemic to try to predict the number of new infections and deaths in sub-Saharan Africa from now until 2020, depending on whether control efforts focused on prevention, treatment or both. By far the most effective way of decreasing new infections and deaths was to combine the two approaches. According to these estimates, more than 29 million fewer new infections and 10 fewer million deaths might be prevented by integrating prevention and care.

Coordination

During 2004, coordination and collaboration among "3 by 5" partners and other organizations have improved significantly at the international and national levels. The "three ones" concept has gained momentum within countries and among donors and technical agencies. Harmonization of efforts to combat HIV/AIDS, including "3 by 5", is essential and must continue.

Strengthening health systems

The year 2005 is an important opportunity to promote equitable and sustained development in poor countries. Weak health systems are a leading obstacle to achieving health-related Millennium Development Goals in many of the most needy countries. "3 by 5" presents an opportunity to address the core underlying issues: a skilled health sector workforce, sound information systems, a well-managed and regular supply of drugs and other supplies and fair and sustainable funding systems.

Beyond "3 by 5"

The next 12 months will see unprecedented activity by many countries in the field of HIV/AIDS. They will also need to look forward and plan beyond 2005. Mid- and long-term strategies will have to be developed, new targets set and resource needs estimated. Most importantly, we must learn how to evaluate our efforts – and where necessary, change our approach "on the fly".

Assessing treatment scale-up and implementing lessons learned is a critical component of the "3 by 5" effort. Never before has so complex a public health campaign been implemented in such a short space of time. Effective operational research, knowledge management and training are critical and will offer significant benefits to all efforts to treat illness in developing and transitional countries.

Enrolling 2.3 million new people on ARV therapy in the next year is clearly the most difficult task the global public health community has ever faced. However, we should be encouraged by the rapid progress we have witnessed in the last six months. The most successful countries are and will continue to be those with strong political and financial commitment and effective partnerships.

"3 by 5" started as the declaration of an emergency. It is now evolving into a global movement for access to treatment, given life by governments, people living with HIV/AIDS and their communities, health care workers, NGO's, businesses, donors and international organizations. Working together, remarkable things have happened. Maintaining these partnerships may enable us to finally face down the most fearsome epidemic of our time.

[25] Salomon JA et al. Integrating HIV prevention and treatment: from slogans to impact. *PLoS Medicine*, 2005, 2(1): e16.