

## WHO/UNAIDS

### **Estimated cost to reach the target of 3 million with access to antiretroviral therapy by 2005 (“3 by 5”)**

#### ***Introduction***

This document explains the assumptions used to estimate the cost of providing life saving antiretroviral drugs to 3 million people in developing countries by the end of 2005 (3 by 5). These estimates reflect the 3 by 5 strategy and model of care as outlined at the WHO/UNAIDS International Consensus Meeting on Interim Recommendations for Technical and Operational Procedures for Emergency Scaling up Antiretroviral Treatment in Resource-Limited Settings, November 18-21, 2003, Lusaka, Zambia.

#### ***Methods***

The estimated costs represent the total resources required to reach the target of 3 by 5. Costs are based on country-specific data for countries from different regions of the world, that account for 91% of the target coverage.

The Zambia Consultation meeting defined an implementation strategy of providing access to antiretrovirals to HIV/AIDS patients that is feasible to implement in resource-limited settings. Therapy for AIDS patients will be initiated at district hospital/primary health facilities through doctors/nurses for prescription and clinical follow-up, and community health workers/trained lay volunteers for adherence and treatment support.

*Patient costs* include HIV testing and counselling including condom distribution, antiretrovirals - both first and second line drugs for WHO Stage 3 and 4, PMTCT for those testing positive in antenatal care clinics treatment and are WHO Stage 1 or 2, treatment and prophylaxis of opportunistic infections (OIs), palliative care, laboratory tests for toxicity for those showing signs of toxicity.

*Programme costs* include training for doctors, nurses, community health workers and lay volunteers, supervision and monitoring, increasing the capacity of the drug distribution system, recruiting community health workers, universal precautions, and post exposure prophylaxis. It also includes purchasing of CD4 machines in low income countries in 2005.

*Note* that these elements relate only to the 3 by 5 strategy and only those preventive activities required to support it directly. They do not include scaling up other interventions, assuming these will continue at the current rate. They do not include major changes to the health system infrastructure given the short time frame until 2005.

## Results

The results are presented for four scenarios with different assumptions of the growth in coverage to reach the target of 3 million by the end of 2005 and different drug costs. The different assumptions considered in this analysis are:

### Coverage assumptions:

- (1) 10% of the target is met in 2004, and 90% in 2005.
- (2) 25% of the target is met in 2004, and 75% in 2005.

### Drug cost assumptions:

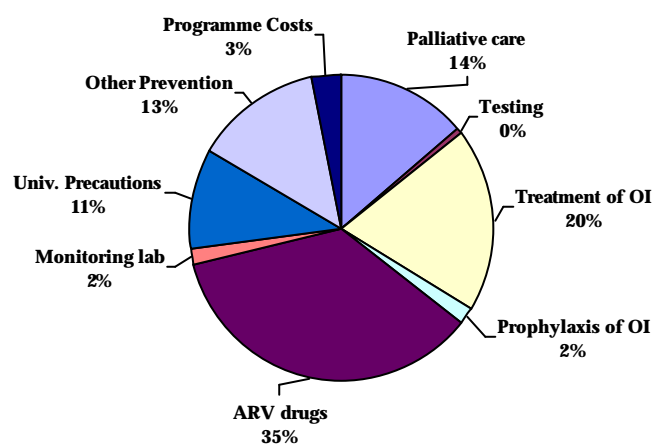
- (A) “Higher cost” – Unit cost of drugs as currently available with best prices provided by the WHO Essential Drugs and Medicines.
- (B) “Lower cost” – As negotiated by the Clinton Foundation applied to all countries.

**Table 1. Estimated cost of 3 by 5, 2004-2005 (\$billion)**

SCENARIO:	Costs in 2004 *	Costs in 2005 *	TOTAL 2004-2005
<b>1A:</b> 10%/90% with higher drug costs	\$2.20	\$3.20	\$5.40
<b>1B:</b> 10%/90% with lower drug costs	\$2.20	\$2.80	\$4.90
<b>2A:</b> 25%/75% with higher drug costs	\$2.34	\$3.20	\$5.50
<b>2B:</b> 25%/75% with lower drug costs	\$2.20	\$2.70	\$4.90

\* costs are rounded up to two decimal points

**Figure 1. Total costs of 3 by 5 (Scenario 2A)**



Note that these estimates supersede previous estimates for the care component of the comprehensive response to HIV/AIDS epidemic. They do not represent an additional funding requirement over that estimated by UNGASS.

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