

BACKGROUND PAPER for the
**CONSULTATION ON ETHICS AND EQUITABLE ACCESS
TO TREATMENT AND CARE FOR HIV/AIDS**

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**“3 BY 5”, PRIORITY IN TREATMENT,
AND THE POOR**

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Introduction^{1, 2}

The central issue vis-à-vis 3 by 5 and the poor is the distribution of an increased supply of anti-retroviral drugs (ARVs). This in turn poses critical questions for both countries as well as WHO as to how the Initiative is to be implemented — given that the numbers in need of ARVs is larger than the coverage envisaged by 3 by 5, how is the criteria for prioritisation for treatment to be nested within the clinical criteria and how is this to be made feasible in implementation in a way that secures the health needs of prioritised groups in the first instance and, within these, the poor? The first question is addressed by the WHO paper on ethical criteria for selection of beneficiaries, the second is discussed here with respect to institutional and systemic mechanisms at the national level.

The context

The country context for implementation of 3 by 5 is one of weak health systems and limited capacity in effective delivery of even the very basic, non-curative care to a significant proportion of the population, especially the poor. The consequences of HIV/AIDS have further debilitated these inadequate health systems, particularly with respect to human resources. Unless a supply side response is accompanied with a feasible pro-poor implementation strategy, it could result in exacerbating the situation further: an expensive drug, now better available and at a subsidy is a powerful incentive for increased parallel market activities. Such leakages and re-sales could be at any point in the system, including at the point of delivery, especially as health workers themselves have fear, and often high rates, of actual infection. And, as a result, those who receive antiretroviral treatment (ART) would continue to be the better-off — either better placed socially to pre-empt subsidised treatment or better off economically to be able to pay for treatment.

The opportunity

However, there is an important opportunistic element in the current effort against HIV/AIDS.

There is exceptional attention on the epidemic as a health and development issue with strong political momentum at both global and country level. Further, substantial international funds have been committed to fight the disease, channelled mainly through the Global Fund to Fight AIDS, TB and Malaria (GFATM). This presents

The key issue for 3 by 5 is prioritising the distribution of ARVs in the context of weak health systems with little capacity for effective coverage of priority groups, especially the poor.

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a unique chance to capitalise upon, to combat HIV/AIDS as well strengthen health systems in developing countries. However, political commitment and momentum also puts governments under pressure to perform and the while outcomes may indeed be legitimate, there might need for monitoring results.

What then are lessons learnt vis-à-vis effectively overcoming health systems bottlenecks to address HIV/AIDS treatment needs, especially those of the poor, which may be combined with the political commitment for a comprehensive country strategy for 3 by 5?

Lessons learnt: HIV/AIDS

Local success with ART

Micro level successes are usually associated with NGOs or public sector 'pilots' which combine a comprehensive approach to service delivery around ARVs. For example, in Malawi, Médecins Sans Frontières (MSF) has effectively managed resources and is providing treatment at two sites. Drugs are purchased directly from the manufacturers and supplied to clinics — these operate from out-patient departments

(1) See Annex I (starting page 4) for the background paper used to develop this Issues Brief.

(2) Poverty in this document is defined in the broadest sense in line with Sen's multi-dimensional approach as captured by the Human Development Index (HDI) was first used in HDR 1990). See Annex II on page 14 of this document.

and provide free ARVs as part of a complete care programme which includes voluntary counselling and testing (VCT), prevention of mother-to-child transmission (PMTCT) and treatment of infections. At one site MSF also provides home-based care for which it draws upon community based health workers as a short term measure to overcome human resource shortages. The challenge is to replicate these on a larger scale — NGO experiences often remain 'islands of success' of 'universally' provided free care, without the challenges of prioritising treatment or capturing the poor.

Summary issues for a pro-poor focus in 3 by 5

- **Increased availability of ARVs must be accompanied by clear procurement and fair distribution guidelines**
- **Limited access — physical and financial — to hospital facilities for treatment can be overcome through out-reach approaches that secure care for disadvantaged groups**
- **Communities are important alternative resource pools for health care workers, especially in poor, rural areas**

National success with ART

At the macro level, Botswana and Brazil have had national level success in providing universal access to ART — that secures care for the poor — which have been achieved against the backdrop of an effective, existing primary health care network but with very different prevalence rates. Botswana has the one of the highest in the world while Brazil at 0.65 is very low by global standards. Both countries used strong political support and social activism to develop a HIV/AIDS strategy backed by legislation, standards and guidelines for implementation and funded through public financing mechanisms. Two additional elements made these successful responses possible: in Botswana, the human resource capacity was expanded by recruiting nurse practitioners and community nurses at primary health care levels to coordinate HIV/AIDS services; in

Brazil financial feasibility of universal ART was made viable by its patent law that does not provide protection to drugs developed before 1997 — the use of generic drugs cut the cost of ARV down to one-fourth of the international price.

Success in prevention

Haiti, Thailand and Uganda have had macro success in preventive activities. These have been designed on disease surveillance, implemented through existing networks and partnerships — in Thailand through STD clinics and in Haiti and Uganda through public-private provider partnerships, with the government playing a prominent governance role with respect to information gathering and dissemination; and planning, coordinating and monitoring implementation. The challenge here is to replicate the experience in curative care and in other settings.

Two specific issues: GFATM and communities

Two additional HIV/AIDS specific aspects need to be highlighted with respect to 3 by 5 and the poor. First, as mentioned earlier, a large portion of international monies available for 3 by 5 is administered through the Global Fund to Fight AIDS, TB and Malaria (GFATM). The funding process requires all stakeholders to participate in country cooperation mechanisms (CCM) through which countries forward requests for grants and the technical review includes appraisal of proposals vis-à-vis spending to improve care for vulnerable groups. There is an opportunity here to have countries focus on the health needs of the poor as well strengthening health systems to be more responsive to these groups. This is particularly important as, given the volume of funds relative to national spending on HIV/AIDS, GFATM grants and associated country proposals have the potential of setting the treatment agenda in countries.

Second, specific issues around HIV/AIDS give communities an unprecedented role in treatment

of the disease. The first step in HIV/AIDS treatment is diagnosis and for any progress in implementation, the supply of VCT must be met by effective translation of need into demand for the service. The stigma attached to HIV/AIDS superimposes itself on traditions and social exclusionary attitudes, reinforcing and deepening existing inequities in utilisation of health services. Demand stimulation requires awareness of the disease as well as behavioural changes to facilitate access both of which, in turn, require the 'medium' of community for effective translation into practice. On the supply side, effective implementation in weak health systems requires community participation, especially for monitoring and accountability. In the treatment of HIV/AIDS, as noted above, a critical shortcoming is staff availability and communities provide a valuable resource base for non-traditional health workers.

Success with other initiatives: TB

The National TB Programme in Malawi provides an example of a initiative that, using a WHO recommended international framework and programme for TB control has been able to reach national coverage through:

- a well established policy framework and five-year development plan supported by national standards and guidelines;
- strong planning implementation and reporting cycle;
- government leadership to support the policy framework, which has engendered joint donor/GoM partnership to implement the programme through basket funding;
- training, supervision and monitoring implemented at all levels of health systems;
- an uninterrupted drug and commodity supply;
- national guidelines implemented by all facilities with reporting integrated into the national database;
- well established programme of operational research, which coupled with strong leadership has the potential to respond to

the changing context of the HIV/AIDS epidemic and reforms such as the national decentralisation policy. While learning from this experience, it is important to keep in mind the different clinical requirements between TB treatment and ART; and that the initiative was designed and implemented as a vertical programme.

Summary issues for a pro-poor focus in 3 by 5

- **GFATM grant process provides an opportunity to have countries develop pro-poor treatment policies**
- **Mobilising communities is critical both for demand stimulation as well as implementation, including effective monitoring among disadvantaged groups**

Conclusions

Country experience in successfully overcoming health systems bottlenecks to provide ART to the poor suggests that as a policy primary health care is the relevant approach with respect to its essential components — addressing the health needs of the community through a mechanism anchored at the lowest level of care and in the context of overall country characteristics. As a strategy to deliver particular health goals of 3by5, especially to the poor, and to strengthen health systems, certain areas need to be strengthened. Specifically,

- Strong government leadership with respect to ART, especially in legislation; setting standards and guidelines; and disease surveillance and systems monitoring needs to be combined with decentralised and participatory approach to implementation
- Sustainable financing of ART through mechanisms that provide protection to poor
- Secure procurement and fair distribution of ARV
- Service delivery that can draws on community participation to overcome human resource constraints in the short run
- Informing communities on the epidemic and its treatment to stimulate demand

ANNEX I 3 by 5: Reaching the poor³

This paper examines how health system institutions and mechanisms need to be strengthened in the context of 3 by 5 to secure treatment for priority groups, especially the poor. It draws on country experience for lessons learnt in successful ART delivery to support the Initiative in providing fair access to treatment.

1. 3 by 5: The what, why, where and how

At the centre of 3 by 5 is scaling up ART from the 400,000 cases currently treated (of the 6 million in need) to 3 million by 2005. The initiative is a response, in the words of J.W. Lee, to a *global health emergency*⁴ to avoid a crisis of unprecedented magnitude, *(T)his crisis is not about numbers, it is about human suffering and the failings of development* (Peter Piot).⁵ The focus is to be on 34 'highest burden countries' which together account for 91 per cent of the global need for ART.⁶ Within core principles of urgency, equity and sustainability, the strategic activities of 3 by 5 fall into five categories or 'pillars':

- (i) global leadership;
- (ii) country support;
- (iii) standardized tools for delivering ART;
- (iv) secure supply of drugs and diagnostics; and
- (v) dissemination of new knowledge and replication of 'successes'.⁷

This paper elaborates cases of replicable 'successes' that incorporate the other pillars and

could facilitate adherence to the core principles of 3 by 5.

Scaling up ART response to a global health emergency in the highest burden countries in an equitable and sustainable manner.

2. The context

The country context for implementation of 3 by 5 is one of weak health systems and limited capacity in effective delivery of even the very basic, non-curative care to a significant proportion of the population, especially the poor. The consequences of HIV/AIDS have further debilitated these inadequate health systems, particularly with respect to human resources - *(I)n many countries on the African continent, the health system is not collapsing, it has collapsed.*⁸ And, unless a supply side response is accompanied with a feasible pro-poor implementation strategy, it could result in exacerbating the situation further: an expensive drug, with better availability at a subsidised price but still in short supply, is a powerful incentive for increased parallel market activities. Such leakages and re-sales could be at any point in the system, including at the point of delivery, especially as health workers themselves have fear of, and often high rates, of actual infection. As a result, those who receive ARTs would continue to be the better-off - either better placed socially to pre-empt subsidised treatment or better off economically to be able to pay for treatment.

The key issue for 3by5 is prioritising the distribution of ARVs in the context of weak health systems with little capacity for effective coverage of priority groups, especially the poor.

3. The opportunity

However, there is an important opportunistic element in the current effort against HIV/AIDS. There is exceptional attention on the epidemic as a health and development issue with strong political momentum at both global and country level. Further, substantial international funds have been committed to fight the disease, channelled mainly through GFATM. This presents a

(3) Poverty in this document is defined in the broadest sense in line with Sen's multi-dimensional approach as captured by the Human Development Index (HDI) was first used in HDR 1990). See Annex II on page 14 of the document.

(4) *Treating 3 million by 2005: Making it Happen - The WHO Strategy*, WHO/UNAIDS 2003.

(5) Presidential Fellows Lecture, World Bank, 20 November 2003.

(6) If these countries reach 50% coverage, an additional 2.7 million people (i.e. 90% of 3 by 5 target) would receive treatment with ART.

(7) *Treating 3 million by 2005: Making it Happen - The WHO Strategy*, WHO/UNAIDS 2003.

(8) J.W. Lee cited in *The Lancet*, December 2003.

unique chance to capitalise upon, to combat HIV/AIDS as well strengthen health systems in developing countries. Importantly, political commitment and momentum also puts governments under pressure to perform and the while outcomes may indeed be legitimate, there is need for monitoring results.

3 by 5 has the opportunity to capitalise on a unique political momentum around HIV/AIDS at both global and country level.

What then are lessons learnt vis-à-vis effectively overcoming health systems bottlenecks to prioritising HIV/AIDS treatment, especially the needs of the poor, which may be combined with the political commitment for a comprehensive country strategy for 3 by 5?

The following sections bring together country experiences in delivering ART at two levels: first, for the various components of the health system and at the local/micro level and, second, at macro/national level. For each level, the issues in relation to HIV/AIDS are presented along with how countries have effectively dealt with them to deliver treatment. Also, the essentials of other disease programmes — TB — are discussed for relevant experiences. From this summary points are highlighted to support 3 by 5 in developing requisite institutional and systemic mechanisms for the equitable provision of ART. It is relevant to note here that there is not always direct evidence on health systems successfully implementing a specific policy of priority treatment or of reaching the poor but, rather, indirect information is used to draw inferences on actions that could potentially address the needs of these groups.

4. Lessons learnt

The first set of country cases in this section refers to 'steps in the right direction' taken to tackle HIV/AIDS i.e. they illustrate mechanisms used to tackle one particular health component or 'islands of excellence' that have overcome all health systems bottlenecks but are very localised experiences. The challenge in these coun-

tries is to address all health systems weaknesses in a comprehensive strategy and, with micro successes, to extent them to a national-scale treatment strategy. The second set of countries in fact examines HIV/AIDS successes which are country-wide in their scope - three of these are with respect to HIV/AIDS prevention with systemic prerequisites in place for the inclusion of treatment activities. Botswana and Brazil provide the only examples of effective provision of ART through four key health systems inputs: existing and functioning primary health care systems; strong political support and stakeholder participation, especially communities, in implementation of universal provision of HIV/AIDS treatment; substantial public financing of ART; and monitoring of service delivery. The final illustration is that of TB in an attempt to draw lessons from other disease control programmes. Importantly, none of the micro or national level successes in ART delivery have had to prioritise care — provision was free and 'universal' — making the strengthening of health systems as 3 by 5 rolls out critical for effective coverage of priority groups and the poor.

4. a. Components of the health system

(i) Stewardship. The stewardship role of government is critical in first, securing a prominent place for health in the overall development policy and reflecting this in distribution of budgetary allocations to the sector, including spending on levels of care and items of expenditure that have the greatest impact on the poor and, second, to inform, regulate, mandate and monitor health sector activities so that the focus on equity and sustainability is reinforced. Accordingly, the need for strong government leadership in successful planning and effective implementation of a strategy to combat HIV/AIDS is examined at both levels.

Health and macro policy

Two inter-related issues around international funding of HIV/AIDS need to be considered in the context of health and broader macro issues

3 by 5 and improving access for priority groups: Strengthening stewardship

- ❖ **Use current political momentum around 3 by 5 to emphasise the health-development nexus as highlighted by other initiatives like the CMH and place health prominently in the national agenda vis-à-vis macro policy so national budgets and expenditures reflect priorities in care.**
- ❖ **Build country capacity to generate information on HIV/AIDS to assist in the formulation of appropriate strategies to implement 3 by 5 as well as to monitoring its impact on priority groups, especially the poor.**
- ❖ **Support an accountable, transparent process of decentralisation through standards and guidelines backed by necessary legislation, regulation and monitoring which allows the system to be more responsiveness to local/priority needs as well as facilitates the integration of 3 by 5 activities into the health system.**

at country level.⁹ First, with large amounts of resources being made available (mainly through the GFAMT), countries perceive the need to balance this with activities traditionally considered 'productive'. This has led to 'ceilings' on health sector budgets at levels that are thought to keep inflation in check and the exchange rate favourable to 'get the 'macro-fundamentals right'. If GFATM funds are included in these ceiling and a corresponding amount of resources reduced from other sources, including public expenditure, this would distort health sector activities at country level. Countries need to use strong leadership along with other initiatives like the CMH to assert priorities at the national level. Secondly, the GFATM funding process, while clearly requiring all stakeholders

(9) Dodd, R. and A. Singh (2003). *Uganda's PRSP: a case study*. HDP/SDE, WHO

(10) Castle, S. (2003). Doubting the existence of AIDS: A barrier to voluntary testing and counselling in urban Mali. *Health Policy and Planning*, 18: 146-155.

(11) Aitken, J-M and J. Kemp (2003). *HIV/AIDS, Equity And Health Sector Personnel In Southern Africa*, Equinet, Discussion Paper 12. <http://www.equinet africa.org/policy.html>

(12) Mbengue, A. and A. Kelley (2001). *Funding and implementing HIV/AIDS activities in the context of decentralisation: Ethiopia and Senegal*, Special Initiative Report No. 34. PHR. <http://www.phrplus.org/hivpubs.html>

to participate in country cooperation mechanisms (CCM) through which countries forward requests for grants also underlines the importance of securing care for vulnerable groups. There therefore a real opportunity here for governments to develop and implement equity enhancing health policies.

Health and HIV/AIDS policy

The first critical function of government with respect to HIV/AIDS is to provide complete information about the disease: its causes, preventive and curative options and health care provision available. This is crucial for both demand stimulation as well as effective supply of the some key inputs — human resources — and may require establishing a disease surveillance programme in the first instance (see the examples of National Level Success below).

In Mali, even in the capital Bamako, there is doubt about the existence of AIDS and a major demand side barrier to VCT activities.¹⁰ In Southern Africa perceived risk of infection based on incomplete information determines both voluntary out-flows from health service as well provider behaviour towards HIV/AIDS patients, key factors in an area of constrained human resources and quality of care.¹¹

A feature of governance that has had some positive consequences and may be important vis-à-vis distributional issues for an initiative with an 'emergency' modus operandi is decentralisation.

In Senegal¹² decentralisation has allowed local decision-making and implementation of HIV/AIDS activities to be integrated into the health system with more resources and a stronger public-private partnership in service delivery. However, complete integration of local bodies and activities at higher levels remains a shortcoming of this reform. One tool employed to facilitate this in the Bamako Initiative — which aimed at increased utilisation of primary care facilities through better basic drug availability financed by user fees and managed locally - were clear, simple guidelines for decisions on fee collection, including exemptions, use of revenues

raised and monitoring.¹³ In fact, one of the reasons decentralisation did not function effectively in the context of HIV/AIDS prevention in Ethiopia was the lack of standard guidelines.

Importantly, decentralisation and other stewardship activities need to be accompanied by appropriate legislation, regulation and monitoring and evaluation guidelines.

In South Africa, the national policy on confidentiality relating to HIV/AIDS was initially founded on rural African models of 'shared confidentiality' as a way of ensuring community-based support for destigmatising the disease. Its review has raised concerns about the effectiveness of a policy that now emphasises individual rights, assuming a more urban constituency and providing an enhanced role for professional counselling - in sum, effectively distancing the community, a critical resource base for supporting health systems activities in HIV/AIDS, especially for the poor.¹⁴

Regulation, more than guidelines, in drug procurement, distribution and use in all sectors — public, private and voluntary — is key for the success of a treatment based HIV/AIDS initiative in terms of equitable and quality care.¹⁵

(ii) Financing. How ART is financed critically impacts who receives treatment. The financing gap between international commitments and resources needed remains substantial. Besides the volume of resources needed, there is the additional issue of sustainability of external funding. Countries must explore domestic financing mechanisms that provide effective protection against catastrophic costs associated with HIV/AIDS treatment, particularly for the poor. Public collection and pooling is the most direct mechanism to finance government priorities in developing countries — regulatory capacity is usually too inadequate to support cross-subsidisation from the private sector.

Zimbabwe has created a National AIDS Trust Fund based on a three per cent individual and corporate tax to support its HIV/AIDS activities.¹⁶ This has been an effective mechanism to raise funds but lacks transpar-

3 by 5 and improving access for priority groups: Strengthening financing

- ❖ **3 by 5 will need to support the mobilisation of funds, both internationally as well as domestically, to meet resource needs for the Initiative and beyond, to ensure financial sustainability in the fight against HIV/AIDS**
- ❖ **The Initiative will also need to help countries develop financing mechanisms that provide protection, especially to the poor, against the catastrophic cost of HIV/AIDS health care, to ensure that ability to pay doesn't become, in effect, the rationing factor in access to treatment**

ency vis-à-vis distribution and disbursement. The experience of community-based health financing schemes in Sub-Saharan Africa has shown a potential for effective protection for the poor but HIV/AIDS treatment may be beyond the scope of this mechanism: HIV/AIDS poses problems both for the financial sustainability as well as the quality of services such schemes can provide.¹⁷ The Bamako Initiative in Africa was a recent attempt, though in a different context, at using cost-recovery to finance drug availability at the facility level. The experience showed that the set of health systems conditions required as a pre-requisite for successful implementation were too difficult to satisfy¹⁸ — these bottlenecks remain and with the substantially higher costs involved with ART, user charges is not a feasible supplementary financing option.

(13) Singh, A (2002). *Reviewing the impact of user fees: The African experience*, Health Financing Technical Brief, EIP/WHO.

(14) Seidel, G. (1996). Confidentiality and HIV status in Kwazulu-Natal, South Africa: Implications, resistance and challenges. *Health Policy and Planning*, 11:418-427.

(15) Laing, R.O., Hogerzeil H.V. and D.Ross-Degnan (2001). Ten recommendations to improve use of emdices in developing countries. *Health Policy and Planning*, 16: 13-20.

(16) Ray, S. and T. Kureya (2003). *Zimbabwe's Challenge: Equity in Health Sector Responses to HIV and AIDS*. EquiNet Discussion Paper 9. <http://www.equinafrica.org/policy.html>

(17) Hsi, A.N, Edmond, J. and A. Comfort (2002). *Preliminary review of community-based health financing schemes and their potential for addressing HIV/AIDS needs in Sub-Saharan Africa*. Technical Paper, PHR. <http://www.phrplus.org/hivpubs.html>

(18) Singh, A (2002). *Reviewing the impact of user fees: The African experience*, Health Financing Technical Brief, EIP/WHO.

3 by 5 and improving access for priority groups: Strengthening resource availability

- ❖ **Improved drug availability through 3 by 5 must be accompanied by procurement and distribution procedures that ensure ARTs actually reach priority groups, especially the poor.**
- ❖ **Implementation in under-served areas would need to explore alternatives to hospital care for reasons of both physical and financial access for the poor.**
- ❖ **To sustain the effort to combat HIV/AIDS, WHO needs to work with countries to anticipating international patents on new drugs and lobbying for exemptions to keep prices down, a key factor in the limited use of ART thus far.**

Strengthening service delivery

- ❖ **Key for the success of 3 by 5 is preserving current human resource capacity through both salary incentives and especially priority for treatment in case of infection.**
- ❖ **3 by 5 would also need to increasing capacity through widening the pool from which health worker are drawn to include community and traditional healers, especially in poor, rural areas.**

(iii) **Resource availability.** There is a considerable thrust around drug availability but procurement and equitable distribution of ART/diagnostic equipment needs to be secured as well to ensure fair access to care at country level. Drug/diagnostic shortages are a persistent problem in developing countries especially in rural areas and, as a result, the cost of these inputs is often found to be inflated, (with quality being spurious at times too). As discussed above, procurement and distribution of ART will need to be monitored carefully to avoid leakages and re-sale in parallel markets that could undermine the entire effort of the treatment-

(19) Kemp, J., Aitken, J.M., LeGrand, S. and B. Mwale (2003). *Equity in Health Sector Responses to HIV/AIDS in Malawi*, Equinet, Discussion Paper 6. <http://www.equinet africa.org/policy.html>

(20) As agreed at the Doha meeting of the WTO. http://www.wto.org/english/tratop_e/dda_e/dda_e.htm

(21) Singh and Stilwell (2003). The significance of the Cancun (non)outcome for the health sector. *Health Policy*. Forthcoming.

based initiative. Further, ART requires hospital-based care which severely limits access for a substantial number of those in need - home-based care is an option but the human resource constraint would still apply.

In Malawi, both government and NGOs (MSF) have effectively managed resources and each is providing treatment at two sites.¹⁹ Drugs are purchased directly from the manufacturers and supplied to clinics - these operate from out-patient departments and provide ART as part of a comprehensive care programme which includes VCT, PMTCT and treatment of infections. At one site MSF also provides home-based care. The challenge is to expand these practices to a national scale which would require integration into health systems of these micro-successes based on a simple and equity drug procurement and distribution policy as well as innovative home-based care strategy.

A further issue to flag here is the need for international negotiations to safeguard future needs for new drugs. There is evidence of resistance developing to ARVs and to ensure that poor countries have access to cheaper, generic drugs as new treatments are developed, these need to be retained as responses to public health emergencies, a category exempt from the general TRIPS agreement on a 20 year patent for new medicines.²⁰ There is considerable pressure from pharmaceutical companies for strict limitations to this category and the case for HIV/AIDS treatment needs to be built early and forcefully.

(iv) **Service delivery.** Human resources shortages are a major bottleneck to effective service delivery in developing countries, particularly in poor, rural areas. This situation is made worse in the treatment and care of HIV/AIDS patients due to fear of, and actual, infection rates among health workers. Preserving existing capacity therefore requires looking beyond tradition incentive mechanism — e.g. salary increases to reduce the out-flow of nurses to developed countries²¹ — to prioritising health workers for HIV/AIDS prevention and treatment as highlighted in the Ethics Framework for 3 by 5. Innovative means that draw on other

pools of resources may be the only way to enlarge capacity in the short run.

In Malawi, MSF has drawn upon community based health workers for treatment delivery, especially where the mode of delivery is home-based care²² as have two home-based care HIV/AIDS and TB projects in Zambia²³. In Uganda, a rise in public sector salaries caused a major in-flux of workers from the private non-profit sector. These faith-based organisations provide over 50% of all health care and are concentrated in disadvantaged locations. To prevent disruption of their services the government has assigned public sector staff (at the higher public sector wages) to NGOs working in under-served areas.²⁴ Also, a trial in Uganda found that private for-profit practitioners may be a good resource group for improving the management of STDs.²⁵ In South Africa, a national HIV/STD programme that focused on traditional healers for a 'cascading' training programme successfully trained over a 1000 in 10 months from an initial resource base of 28 healers on prevention activities.²⁶ A similar approach of 'up-grading' or 'expanding' skills could be used to garner in workers for HIV/AIDS treatment.

(v) Community involvement Specific issues around HIV/AIDS give communities an unprecedented role in treatment of the disease. The first step in HIV/AIDS treatment is diagnosis and for any progress in implementation, the supply of VCT must be met by effective translation of need into demand for the service. The stigma attached to HIV/AIDS superimposes itself on traditions and social exclusionary attitudes, reinforcing and deepening existing inequities in utilisation of health services. Demand stimulation requires awareness of the disease as well as behavioural changes to facilitate access both of which, in turn, require the 'medium' of community for effective translation into practice. On the supply side, effective implementation in weak health systems requires community participation, especially for monitoring and accountability. In the treatment of HIV/AIDS, as noted above, a critical shortcoming is availability of staff, at health facilities and for home-based

3 by 5 and improving access for priority groups: Strengthening community involvement

- ❖ **Communities are pivotal in disseminating information on HIV/AIDS, including treatment and, critically, reducing the stigma that constraints demand, especially among groups already subject to exclusion**
- ❖ **3 by 5 needs, from the start, to build capacity at community level for participation in service delivery as well monitoring of the Initiative with respect to effective coverage of priority groups, especially the poor.**

care and communities provide a valuable resource base for non-traditional health workers.

Two specific inputs are needed to exploit the potential of communities to successfully contribution to the treatment initiative: first, comprehensive information on HIV/AIDS, ART and available health service options and second, capacity building for participation in HIV/AIDS treatment activities.

Improving access for priority groups: Lessons from Botswana

Strong political support backed by commitment of public resources to provision of ART as a priority within universal care

The health system anchored at the lowest level of care with effective referral linkages and provided access to care to over 90 per cent of the population

Community members trained as health worker to overcome human resource constraint in the short-run

(22) Kemp, J., Aitken, J.M., LeGrand, S. and B. Mwale (2003). *Equity in Health Sector Responses to HIV/AIDS in Malawi*, Equinet Discussion Paper 6. <http://www.equinetafrica.org/policy.html>

(23) Nsutebu, E., Walley, J., Mataka, E., and C. Simon (2001). Scaling up HIV/AIDS and TB home-based care: Lessons from Zambia. *Health Policy and Planning*, 16(3): 240-247.

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4.b. Lessons learnt: National-level successes²⁷

(i) **Botswana** has one of the highest rates of HIV in the world on which the government acted strongly with a high-level National AIDS Council that coordinates a multi-sectoral response to the disease. In 2002, the country was the first in Africa to offer comprehensive HIV/AIDS care and treatment to all its population. Within the sector, key health systems components are already well established, lending critical practical support for implementation of the Council's policy recommendations. Health spending consti-

Improving access for priority groups: Lessons from Brazil

Political commitment founded on successful lobbying by the public health community and social activist resulted in a strong national focus on the issue

Free universal care guaranteed access to HIV/AIDS care to all at the policy level and made feasible in implementation by

- ❖ **an existing, effective primary health care system which successfully delivered ART through**
- ❖ **federal standards and guidelines for treatment**
- ❖ **public financing of treatment that removed the financial barrier to access and which was made viable by the use of cheap generic drugs**

tutes six per cent of the of GDP with per capita expenditure being as high as USD191 and, importantly, two-third of this is public expenditure. There is a pyramid of facilities, bottom heavy, which allows 90 per cent of the population access to health care. However, in the human resources sector, in spite of the improving doctor/nurse-patient ratios since 1980, staff scarcity continues to be a constraint (personnel accounted for a shrinking proportion of recurrent spending through the 1990s). The short-term solution has been to recruit nurse practitioners and community nurses with post basic training and deploy them at primary health care levels to coordinate HIV/AIDS services.

(ii) **Brazil** was the first developing country to successfully adopt a policy of universal access

(27) Compiled from various sources.

to ART. Today as estimated 0.65 per cent of Brazilians are infected, a low prevalence by global standards. The fight against HIV/AIDS was against the backdrop of a constitutional guarantee to the right to universal health care as early as 1988. In the 1990s a strong link was forged between the public health community and social activist which lobbied successfully to include AIDS treatment in the universal care package and a law mandating free access to ART was passed in 1996. Three specific aspects of the health systems contributed to effective and equitable service delivery. First, a multi-tier health service delivery structure based on locally managed primary care with strong referral links between levels; second, comprehensive implementation standards and guidelines issued by the federal government helped operationalise the AIDS treatment initiative; finally, ART was financed entirely and adequately by public funds, made viable by Brazil's patent law that does not provide protection to drugs developed before 1997 — the use of generic drugs cut the cost of ARV down to one-fourth of the international price. Also, publicly provided curative care was accompanied by a government-NGO-donor partnership that tackled prevention of HIV to form a comprehensive and inclusive effort at epidemic control and treatment.

(iii) **Haiti** is the hardest hit country with HIV/AIDS outside Africa with an adult prevalence rate of 5 per cent. The epidemic was recognised early in its course and from the start a coordinated response was launched to combat it. This is evident in the entire continuum of disease control and treatment: public efforts and those of the NGO sector, especially religious groups, in preventive activities have been successful in stemming the prevalence of the disease; international cooperation to strengthen local research capacity and data availability has been critical to informed decision-making — this was particularly effective in curtailing the circulation of infected blood: in 1985 40 per cent of the HIV infected women had received blood donations from non-profit blood banks, in 2000 less than

1 per cent of HIV infections were due to blood transfusions; training to scale up capacity of health workers to treat AIDS is being modelled on and carried out by NGOs in collaboration with the Ministry of Health. The public-private partnership has been successful in the area of planning as well as evident from the successful collaborative effort that was awarded a GFATM grant. The government is to use this to building on the success of prevention activities by setting up over 50 self contained local delivery systems each with a referral hospital and primary care network to provide a complete package of HIV care and preventive services. These have already been successfully developed on a pilot basis in both urban and rural areas.

(iv) Thailand shows that a national response that mobilises key government and NGO partners and targets the highest-risk transmission group can be effective in reducing the scope of the epidemic, even when the action is delayed. At the level of political leadership, the government's public health policy vis-à-vis HIV/AIDS is based on a nation surveillance system that identifies the magnitude and nature of the epidemiological, demographic as well as behavioural aspects of the disease. Pilot projects were used as policy impact assessment tools and 'lead' to appropriate revisions before expansion to a national scale of the 100% Condom Programme. Implementation also used the existing STD clinic system - one of the best networks in developing countries - for providing information, free condoms, and treatment as well as monitoring compliance. Importantly, a multi-sectoral, participatory approach at the local level was successful in mobilising visibility at national level. The challenge now is to extend this success beyond high risk groups as well beyond preventive activities to curative treatment.

(v) Uganda was one of the highest hit countries in Africa but has been successful in achieving declines in prevalence rates through the 1990s - today this is at about 5 per cent of the adult population. Treatment and care of AIDS related ailments is limited, including the use of

Improving access for priority groups: Lessons from Haiti

- Success in prevention was made possible by**
- ❖ **strong government action based on strengthened information systems on the profile of HIV/AIDS**
 - ❖ **partnership with NGOs and donors in implementation of the prevention strategy**

Replication in treatment is being attempted through continued political commitment and stakeholder partnership in

- ❖ **establishing primary care networks around nodal referral hospitals**
- ❖ **financing care through public mechanisms (using the GFATM grant) to protect against catastrophic cost of ART**

Lessons from Thailand

Success in prevention through

- ❖ **delayed but strong political and multi-sectoral response to the issue**
- ❖ **successful 'pilots' based on disease surveillance used to formulate national strategy**
- ❖ **implementation priority on high risk groups**
- ❖ **preventive activities 'piggy-backed' on the existing, successful network of STD clinics 'upgraded' to resource centres for continuum of HIV/AIDS care**

Lessons from Uganda

Success in prevention through

- ❖ **individual response by all providers**
- ❖ **diverse approaches pulled together by state provided information and free condoms**

ARVs though new drug initiative with GFATM may change this by building on the success of preventive activities. In Uganda the HIV/AIDS effort has thus far been a combination of diverse programmes initiated by various groups — faith based organisations, NGOs and the government all designed their own prevention approaches — which were held together by a state-run national awareness campaign and distribution of condoms.

4. c. Lessons learnt: Experience from other disease control initiatives

The National TB Programme in Malawi provides an example of an initiative that, using a WHO

**Improving access for priority groups:
Lessons from TB**

**Well planned, coordinated and monitored
strategy, including funding**

**Secure procurement and distribution of drugs
and other inputs**

Guidelines to facilitate service delivery

recommended international framework and programme for TB control has been able to reach national coverage through:

- a well established policy framework and five-year development plan supported by national standards and guidelines;
- strong planning implementation and reporting cycle;
- GoM leadership to support the policy framework, which has engendered joint donor/GoM partnership to implement the programme through basket funding;
- training, supervision and monitoring implemented at all levels of health systems
- an uninterrupted drug and commodity supply
- national guidelines implemented by all facilities with reporting integrated into the national database
- well established programme of operational research, which coupled with strong leadership has the potential to respond to the changing context of the HIV/AIDS epidemic and reforms such as the national decentralisation policy.

While learning from this experience, it is important to keep in mind the different clinical requirements between TB treatment and ART; and that the initiative was designed and implemented as a vertical programme.

5. Conclusions

Country experience in successfully overcoming health systems bottlenecks to provide ART to the poor suggests that as a policy primary health care is the relevant approach with respect to its

essential components — addressing the health needs of the community through a mechanism anchored at the lowest level of care and in the context of overall country characteristics. As a strategy to deliver particular health goals of 3 by 5 and to strengthen health systems, primary health care would need to be modified and adjusted in order to adhere to the core principles within the implementation framework of the five pillars. For 3 by 5 to be equitable and sustainable these specific revisions to/emphasis in the PCH approach, as informed by country experience, may be specified as:

Stewardship. 3 by 5 has taken the lead in bring global attention to focus on the urgency to combat HIV/AIDS. The Initiative now has to use this political momentum to build strong commitment at country level for raising the profile of health overall and HIV/AIDS in particular and for establishing mechanisms that effectively reach priority groups, especially the poor. For this 3by5 must provide country support to:

- gather and disseminate information — for policy and strategy formulation; for monitoring and evaluation; and for general awareness about issues around HIV/AIDS
- establish an inclusive process of decentralisation with the requisite tool for successful implementation, particularly standards and guidelines and monitoring and evaluation criteria
- regulate and mandate, through the legislative process, health activities as appropriate for a pro-poor policy focus

Finance. How ART is financed will critically impact who will have access to treatment and sustainability of any strategy that addresses HIV/AIDS. In developing countries where financial institutions are weak, the state has a key role in health care financing, especially vis-à-vis providing protection to the poor. 3 by 5 has committed to lobby for more international monies for HIV/AIDS treatment that may be channelled via public financing mechanisms. In addition, the Initiative must work with countries to:

- explore collection mechanisms that increase domestic resources for health for financial sustainability
- build and strengthen pooling mechanisms that provide protection against catastrophic cost of HIV/AIDS treatment, especially for the poor

Resource availability. 3 by 5 has made a call for improved international availability of ART. The Initiative now needs to consider issues beyond this, especially if it is to make treatment accessible to priority groups and the poor. Specifically, it needs to assist countries in developing:

- drug procurement and distribution guidelines and mechanisms that are necessary to ensure equitable access
- in the absence of adequate hospital facilities, innovative means of overcoming the infrastructure bottleneck e.g. home-based care, especially for under-served poor populations
- anticipatory legislation at both the global and national level that secures access to generic drugs for any new treatment for HIV/AIDS which guarantees low cost of ART and, therefore, financial access for the poor

Service delivery. 3 by 5 has flagged human resources as the critical factor in achieving the Initiative's goal of ART provision. In the case of HIV/AIDS, general health worker shortages especially in the poor, rural areas of developing countries is further constrained by the impact of the epidemic on health workers. 3 by 5 must emphasise the importance of mechanisms that:

- preserve existing human resource capacity by providing incentive to health workers, included prioritised HIV/AIDS treatment
- explore alternative pools of health workers, particularly the community, and provide them with requisite training in ART

Community participation. 3 by 5 has recognised the unique role of communities in making the Initiative successful, especially with respect to the double exclusion the stigma attached to the epidemic imposes on marginalised groups. Civil society and community groups have already been garnered into the effort and 3 by 5 can use them effectively by:

- using the community as a platform for the dissemination HIV/AIDS information to stimulate demand in response to improved availability of ART
- building capacity at community level for participation in implementation, including service provision and monitoring

ANNEX II Definition of poverty used

Acknowledgement of the complexity of poverty has led to an increasingly multi-dimensional definition of the issue — moving away from the income space to concepts that capture 'well-being'. Correspondingly, measures of poverty have shifted from simply per capita income to attempts to better capture its multi-dimensionality.

A very significant contribution towards a multi-disciplinary measure of poverty was made by the first Human Development Report (HDR), commissioned by the United Nations Development Programme (UNDP) in 1990.³² The HDR series (and subsequent national, sub-national and regional Human Development Reports in 135 countries) advocated a shift in the development debate away from a preoccupation with economic growth toward a more balanced concern for equity, sustainability, productivity and empowerment. The Report's 'signature trademark', the human development index (HDI), has since served as an alternative to GNP (per capita) as a measure of development. A series of global development summits have since reinforced the essential multi-dimensionality of pov-

erty and this is clearly reflected in the recent consensus on the Millennium Development goals, targets and indicators set to benchmark and monitor the eradication of extreme poverty.

Definition

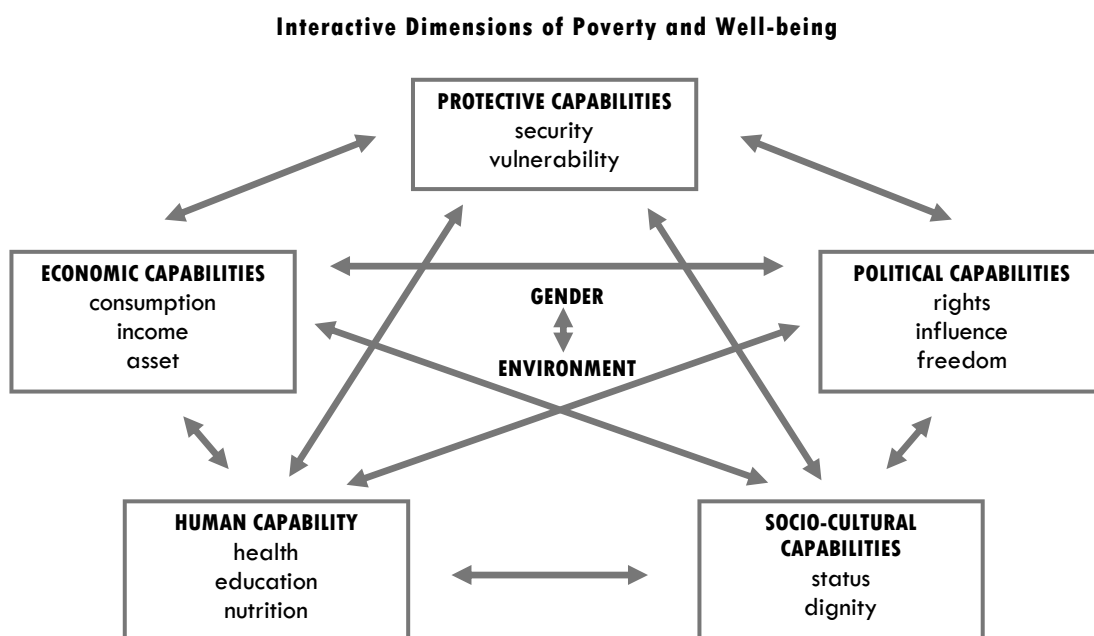
UNDP has formulated two concepts of human poverty and human development: human poverty refers to deprivation of 'means to achieve' (e.g. physical access health care) and basic 'conversion' factors (e.g. social access to health care) that allow individuals to broaden their capability set (e.g. higher productivity); human development refers to processes that broaden individual choices to achieve e.g. freedom.³³

The OECD-DAC Guidelines document on Poverty Reduction provide a useful definition of poverty both with core dimension as well as the interaction between the various dimension and is captured in the figure below.

(32) HDR (1990).

(33) Sen (2000).

(34) OECD (2001).



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