A s of May 2004, Major pledges include: US$15 billion by 2008 through the United States President's Emergency Plan for AIDS Relief; US$5.5 billion has been pledged to the Global Fund to Fight AIDS, Tuberculosis and Malaria; more than US$15 billion had been made available through the World Bank Multi-Country HIV/AIDS Program (MAP).

IMPORTANT INFORMATION

To ensure a comprehensive response to HIV/AIDS, treatment and prevention programmes must enhance and accelerate efforts in many settings.

Prevention and treatment must work together and anyone receiving HIV treatment must be counselled in effective prevention methods. Prevention messages must go together with treatment so that the risk of further infection is minimized.

WHAT IS WHO DOING TO ENSURE THAT WOMEN BENEFIT PROPORTIONALLY FROM 3 BY 5?

Of the estimated five million cases of HIV that occurred last year among adults, about half were women, and this proportion is increasing. It is important to make the most of existing opportunities to reach women with key HIV prevention and care interventions through the development of ethically sound ART programmes, including the articulation of principles that will promote gender equality, that are inclusive of children and marginalized groups, and that maintain an overall pro-poor approach.

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TREATING THREE MILLION PEOPLE LIVING WITH HIV/AIDS IN DEVELOPING AND MIDDLE INCOME COUNTRIES BY 2005 - “3 BY 5”

WHY THREE MILLION PEOPLE ON ANTIRETROVIRAL THERAPY (ART) BY 2005? WHY THIS NUMBER, WHY THIS DATE?

Approximately six million people living with AIDS in the developing world are in need of antiretroviral therapy (ART) due to the seriousness of their illness. Every year, three million people die because they cannot get the treatment they need.

The “3 by 5” target is grounded in the analytical work of a number of scientists prior to the 2001 Special Session of the UN General Assembly. With that, the target was feasible to reach 50% of those in need of ART treatment by this time (therefore three million).

Everyone who needs ART should have access to it. That is the longer term goal “3 by 5”; by regional experts in the work of the World Health Organization. The longer term goal is a global target proposed by WHO and supported by UNAIDS and other partners.

PROVIDING THREE MILLION PEOPLE WITH ART BY 2005 IS A HIGHLY AMBITIOUS TARGET. CAN IT BE DONE?

WHO believes that a target of three million people on treatment by the end of 2005 is achievable, although this will require a major change in the way that WHO, countries and partners work. Important progress has already been made in a number of areas: there is unprecedented high-level political commitment to treatment access; for higher levels of national and international financing are available; there has been a significant reduction in the price of ART; the “3 by 5” strategy includes simplified treatment regimens; a new AIDS Medicines and Diagnostics Service and new delivery guidelines; and there are an increasing number of countries (such as Brazil, Thailand, Uganda and Senegal) where ART has been scaled up successfully.

Every day spent debating whether or not “3 by 5” is feasible, 8,000 people die from AIDS. The time to scale up treatment is now.

IS “3 BY 5” JUST A WHO INITIATIVE?

“3 by 5” is not a WHO project; it is a global target to get three million people living with AIDS on treatment by the end of 2005 that has been adopted by 192 countries at the World Health Assembly held in May 2004. The goal is universal access to treatment for all those who need it. “3 by 5” is a target that many organizations are working to achieve, including national authorities, UN agencies, bilateral agencies, foundations, non-governmental, faith-based and community organizations, the private sector, labour unions and people living with HIV/AIDS. To succeed, full support and participation from all partners and governments is needed.

WHAT IS THE WHO “3 BY 5” STRATEGY?

On December 1, 2003, a strategy document — Making it Happen — was launched by WHO, describing how — with appropriate resources — WHO could contribute to reaching the “3 by 5” target. The strategy outlines key areas in which WHO will work to help countries reach this ambitious target. These include:

- Simplified, standardized treatment regimes for antiretroviral therapy
- Urgent, sustained support to countries to implement “3 by 5”
- New service to ensure an effective, reliable supply of medicines and diagnostics (The AIDS Medicines and Diagnostics Service — AMDS)
- Assistance to countries and developing guidelines for training and capacity building
- Rapid identification and application of new knowledge and successes

WHAT IS WHO’S ROLE IN REACHING THE TARGET?

WHO provides normative guidance and technical assistance to countries to help them scale up their treatment activities. WHO develops and sets normative standards in (for example) prevention and treatment protocols; provides countries with technical assistance to strengthen health systems and to design and implement their programmes; and assists countries in choosing and procuring high-quality drugs and other commodities through its prequalification process (see Prequalification Fact Sheet).
initiatives like the United States President’s Emergency Plan for HIV/AIDS Relief, bilateral funding bodies and national government budgets provide substantial new resources for HIV/AIDS prevention, treatment and care in countries. National governments are responsible for the management and rollout of the programmes to increase treatment. Non-governmental, faith based and community organisations as well as the private sector also contribute to scaling up prevention and treatment programmes.

**HOW DOES THE WHO STRATEGY SIMPLIFY THE PROVISION OF ART?**

WHO has published simplified treatment guidelines to make it easier to increase the availability of treatment in poor countries. The guidelines recommend simplified and standardized approaches for treatment regimens and clinical monitoring so that resource-constrained countries can start ART scale up. Standardizing and simplifying processes in this way also makes it easier to train the thousands of health care workers needed to increase access to treatment.

The number of treatment regimens recommended by WHO has been cut from 35 to four. This makes ART treatment easier to purchase, procure and prescribe meaning that more people can be treated in all countries. The treatment regimens recommended in the 2003 WHO treatment guidelines are comparable to those widely used in developing countries (such as Brazil, Haiti, Malawi and Thailand).

Another key element is the simplification of monitoring, so that easy-to-use tests such as body weight and colour-scale blood tests are used where more complicated and expensive tests for viral load and white cell (CD4) counts are not yet available. The simpler tests, combined with clinical evaluations by adequately trained health workers, can be effective in monitoring the progress of AIDS, the effectiveness of treatment and its side effects.

**DO SIMPLIFIED REGIMENS MEAN SECOND CLASS TREATMENT FOR POOR PEOPLE?**

The regimens that are being recommended are widely used in developed countries. These are not second class treatments. The point is to provide the best and most appropriate treatment to countries with limited resources and infrastructure and to allow these countries to get scale up underway immediately. This is first class therapy in a simplified format.

**ISN’T DRUG RESISTANCE A PROBLEM?**

Because HIV has a very high mutation rate, and because ART should be lifelong for continued use, HIV drug resistance will inevitably emerge among people on treatment even if treatment protocols are followed and adherence is maximized. In many developed countries ART started with single and double combination treatment and resistance did emerge requiring more second line drugs. In contrast, with new WHO ART (2004) scale up guidelines which recommend initiating with triple therapy it is hoped that the emergence of resistance will be delayed and minimized. Despite a high level of drug resistance among people who began ART before triple-drug ART was available, transmitted drug resistance in these countries has not rendered any antiretroviral (ARV) drug ineffective on a population basis for initial HIV treatment. Contrary to popular perception, existing evidence, although limited, shows that resistance is actually higher in rich countries than in developing countries. In North America and Western Europe the resistance ranges from 11-25% while in Brazil, the rate is around 6%.

The “3 by 5” strategy includes several steps to address the potential emergence of ART resistance. Firstly, it is implementing a global standardized surveillance programme for ART resistance in countries scaling up ART to measure the rate of resistance and to help ensure that the public health implications of drug resistant virus are well understood. WHO and partners propose active monitoring of resistance emergence. WHO also recommends studies be done in treated populations who are taking therapy to see if resistance is emerging. Secondly, the strategy acknowledges the importance of putting in place effective pre-treatment education programs and sustained adherence support for patients on ART. Adherence support will form an important component of the curricula for health care providers and treatment supporters which WHO is developing. Finally, encouraging the use of fixed drug combinations will help to ensure that patients receive all the drugs at the right dosage, which is important to prevent drug resistance.

It should be noted that resistance-related risks have never been used as an argument against treatment of sick people in rich countries.

**WHAT ABOUT CHILDREN? CAN THEY BE TREATED IN THE SAME WAY?**

Children and infants can and should be treated. About half of the antiretroviral (ARV) drugs used in adults can be used for ART treatment in children. Aside from limited availability of ARV drugs in children, there are several constraints to expansion of ART in children, including:

- specialized ART tests are needed to diagnose HIV in children less than 18 months as maternal antibodies to HIV are present in all HIV-exposed infants.
- many of the currently available syrup formulations are not palatable (taste terrible), require that large volumes of syrup be taken and/or may need refrigeration and once opened must be used within one month.
- drug doses must be adjusted as a child grows.
- lack of tools to help health professionals in countries to implement and deliver ART for children.

Despite these constraints, children who receive ART respond as well as adults. Thus far, advocacy has largely focused on increasing access to ART for adults and adolescents. Overcoming many of the hurdles that hinder children’s access to ART requires similar advocacy.

WHO has developed guidelines on key aspects of ART in children. In addition, a recent successful meeting with pediatric HIV experts was held in order to explore ways of addressing current gaps and obstacles to care and treatment of HIV-infected children. Guidelines on the diagnosis of HIV infection in HIV-exposed children will be published in the near future; this aims to assist with decision on the timing and choice of HIV testing in children.

Future activities include the development of a comprehensive guide to ART in children and documentation of successful models of care for HIV-infected children. Furthermore, WHO is working closely with UNICEF and other key partners to ensure these forms of technical guidance are incorporated into child health and HIV programmes.

**WHAT ARE FIXED DOSE COMBINATIONS (FDC)?**

Fixed dose combinations (FDC) of ART are the combination of two or three drugs in one single-dose pill and are key to making the treatment process easier for countries to implement. FDCs are a major breakthrough for AIDS treatment in poor countries as they offer significant operational advantages including ease of distribution and storage, the likelihood of greater adherence, reduced incidence of treatment failure and drug resistance.

Their use will significantly further the realization of the “3 by 5” target as the products improve the reliability, sustainability and security of drug supplies, which have so far been major obstacles to expanding access to ART. As in TB or malaria combination therapy, they also ensure that the right dosage of each substance is given to the patient, which will minimize drug resistance.

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WHO has "prequalified" double and triple FDCs (read more about prequalification in the 'Prequalification' information sheet). These FDCs are saving lives now in many countries.

**SHOULD TREATMENT BE PROVIDED FOR FREE OR WILL PATIENTS HAVE TO PAY SOMETHING?**

WHO's position is that ideally, treatment should be free or as affordable as possible for all who need it. However, it is up to individual countries to decide their position on whether drugs will be provided free of charge, according to the means and policy of the country. Experience and evidence shows that when people have to pay for their treatment or any of the associated costs, they cannot always afford the medicines and therefore will not be able to adhere to the treatment. Thus, making the drugs as affordable or as cost-free as possible is essential to maintain equity, prevent resistance and reap the full benefits of treatment both for the individual and society.

**WILL ART BE SUSTAINABLE?**

"3 by 5" is a target. Universal access to ART is the goal. For this to happen, it is essential to strengthen health systems as a whole which will mean making the most of the substantial existing resources in a co-ordinated way to ensure that patients get treatment for life. It is also essential that advocacy efforts to push forward the goal for access continue and that political commitment is mainlined.

The "3 by 5" strategy recognizes that continuity and quality of the drug supply, building health care human resources through continuous training programs, full engagement of local communities in advocacy, programme design, education and information and adherence support are all vital to the longer-term effectiveness of antiretroviral therapy. Well-designed and implemented community-based treatment programs are sustainable. But long-term national and international support will be essential to scale these programs up to meet the ambitious "3 by 5" target and beyond.

**HOW CAN YOU ENSURE THERE ARE ENOUGH HUMAN RESOURCES TO ACHIEVE "3 BY 5"?**

The serious shortage of health workers in many of the countries worst hit by AIDS is clearly a major obstacle. Many health workers have died as a result of untreated AIDS; others have moved to seek better pay and job security in wealthier countries.

Globally up to 100,000 health workers and community treatment supporters need to be trained for their contribution to achieving the "3 by 5" target. This training must be a continuous process to ensure there are enough healthcare workers for continued treatment and care.

From a country perspective, major bottlenecks in successfully responding to human resource challenges in the health sector include the absence of a concerted human resource and training approach to recruiting, training and retaining the workforce necessary to deliver ART; multiple and sometimes conflicting training materials in use; lack of training provider capacity and insufficient quality control and certification systems in the training sector.

In January 2004, WHO published a "Human Capacity Building Plan" for scaling up HIV/AIDS treatment, outlining how WHO and its partners can help countries to overcome these barriers and ensure both the emergency training and recruitment of personnel into the HIV/AIDS workforce and long-term sustainability of human resources in the health sector. WHO is now working with countries to translate this plan into concrete action at a national level.

In addition, WHO has launched an "Integrated Management of Adolescent and Adult Illness" training package for health workers at first level facilities including a basic ART clinical training course, a short course on opportunistic infections, and accompanying aids such as a patient education flipchart. Already some countries have successfully adopted this training approach, and WHO is working with others to support this process.

**WILL THE USE OF COMMUNITY HEALTH WORKERS TO DELIVER MEDICINES UNDERMINE THE SAFETY OF PATIENTS?**

One of the most innovative sections of the "3 by 5" strategy proposes urgent training of tens of thousands of non-medical community health workers to support the delivery and monitoring of treatment for people living with AIDS. Intensive training programmes will enable these non-medical health workers to evaluate and monitor patients, and make sure they receive and are taking their medicines.

Community health workers are critical to making scale up happen and will support the delivery and use of medicines and the monitoring of treatment for people living with AIDS. They will be part of a larger team that will always include a trained clinician. Community health workers will not prescribe medicines or take any of the clinical decisions currently taken by physicians.

**HOW WILL "3 BY 5" CONTRIBUTE TO BROADER DEVELOPMENT GOALS?**

The role of HIV/AIDS in halting or reversing economic and social development in many heavily-affected countries is now well-established. Providing access to ART is not only a necessary response to a public health crisis, it is vital in order to arrest this decline and to rescue faltering health systems. In the longer term, the approaches to human capacity building and service delivery recommended in the "3 by 5" strategy are exactly what is needed to help bring about sustained improvements in health systems overall and to expand the reach and effectiveness of primary health care and care for chronic conditions. There is every reason to believe that ART can help serve as a vehicle for longer-term systemic recovery.

The "3 by 5" strategy contains approaches for sustaining and optimizing existing capacity in countries, for example, by minimizing the need for sophisticated health infrastructure. Few countries, even in the ones, make the best use of existing health infrastructure and capacity to deliver treatment, and support to people living with HIV/AIDS. The fact that more capacity is needed cannot be used as an excuse for inaction. Existing health services can be effectively utilized as the basis for the rapid scaling up of ART, including TB, STI and maternal and child health care in addition to traditional hospital services.

In Brazil, as a result of the national HIV/AIDS treatment programme, it is estimated that between 1994 and 2002, almost 100,000 deaths have been averted (a 50% drop in mortality) through the introduction of ART.

The programme in Brazil clearly demonstrates how scaling up can also help strengthen health systems and dramatically reduce public health costs. As a result of the programme, there has been a significant decline in the number of hospital admissions and cost savings in reduced hospital admissions and opportunistic infections are estimated at more than US $1 billion. The question faced by many countries now is not simply whether it is economically feasible to provide ART, but whether they can afford not to.

**IS WHO ONLY INTERESTED IN TREATMENT FOR AIDS? WHAT ABOUT PREVENTION AND OTHER APPROACHES?**

WHO, UNAIDS, and many other organisations have worked for many years on developing improved programmes for prevention of HIV transmission. We will continue and in fact accelerate our prevention through the "3 by 5" initiative. Prevention activities,