1. INTRODUCTION

This report reviews the progress made in 2009 in scaling up access to selected health sector interventions for HIV prevention, treatment and care in low- and middle-income countries. It is the fourth in a series of annual progress reports published since 2006 by the World Health Organization (WHO), United Nations Children’s Fund (UNICEF) and Joint United Nations Programme on HIV/AIDS (UNAIDS) in collaboration with international and national partners to monitor key components of the health sector response to the HIV epidemic worldwide.1

2010 is a landmark year for the global HIV response. At the 2006 United Nations General Assembly High-Level Meeting on AIDS, world leaders committed to scaling up services and interventions towards the goal of providing universal access to HIV prevention, treatment, care and support by the end of this year (1). Now, as countries and partners prepare to review universal access goals and targets in the months ahead, assessing progress is critical to identify areas where intensified action is needed to increase coverage and impact. This report will support this process in two ways. First, the accurate and up-to-date strategic information in the report will help countries to take stock of their achievements and identify programmatic bottlenecks, service delivery gaps and challenges. Second, the update of the global response will assist the international community in setting policy priorities, defining targets and designing relevant strategies to better support and enhance country responses.

The proximity of 2010 has served to rally and galvanize partners involved in the HIV response at all levels. Encouragingly, 2009 witnessed renewed commitment and resolve towards attainment of universal access and the Millennium Development Goals (MDGs). The launch of UNAIDS’ Outcome Framework has helped focus attention on ten programmatic areas and a range of cross-cutting strategies in which progress must be rapidly accelerated (2).

At the same time, the international community has also moved decisively towards agreeing to virtual elimination of mother-to-child transmission of HIV by 2015 (2). A new global health initiative, spearheaded by the United States Government, will support low- and middle-income countries to improve health outcomes and strengthen health systems, including HIV services. New financial allocations have been agreed to by the Global Fund to Fight AIDS, Tuberculosis and Malaria. WHO’s guidelines on antiretroviral therapy for adults and adolescents as well as children, now recommend initiation of therapy at an earlier stage of the disease, which should further reduce HIV-related mortality and morbidity as well as HIV transmission.

At the same time, the global HIV response has been buffeted by both the global financial crisis and changing public health and development priorities at national and international levels. These events have highlighted the need to enhance the impact of current investments by improving the efficiency, effectiveness and quality of programmes, strengthening linkages between programmes and building systems for a sustainable response.

This report shows that, among 144 low- and middle-income countries reporting programme data this year, eight had already achieved universal access to antiretroviral therapy at the end of 2009, providing treatment to at least 80% of patients in need. Furthermore, 15 countries had achieved the 80% target for coverage with antiretroviral prophylaxis to prevent mother to child transmission of HIV.

Although more countries may reach universal access goals by the end of 2010 as a result of ongoing efforts, global targets for HIV prevention, treatment, care and support are unlikely to be achieved. Importantly, this has implications not only for the HIV response, but also for all other MDGs, particularly MDGs 4 and 5, on child and maternal health. Indeed, as documented by recent research, a lower burden of HIV/AIDS has been associated with considerably greater progress towards the achievement of child mortality and tuberculosis (TB) goals than economic growth itself (4). In the absence of HIV, maternal mortality worldwide would have been lower by about 6% in 2008 (5) and a recent academic study (6) has estimated that up to 18% of pregnancy-related deaths may be due to HIV.

In spite of all the challenges and constraints, this report demonstrates that, with intensified and accelerated efforts, countries can achieve universal access. Health-care workers have been trained, critical infrastructure has been upgraded, and health systems are gradually being strengthened. Although much remains to be done and improved, millions of new HIV infections have already been averted and millions of people are alive today as a result of investments in HIV over the past few years.

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1 Two other important joint publications, to be released later in 2010, will complement the health sector-related information presented and discussed herein. The Aids Today: 2010 UNAIDS Global Report will discuss the current status of the epidemic and the multisectoral response at the global and national levels, and the Stoklising report on children and AIDS will present additional critical data on the progress made and challenges in scaling up services for women, children and young people affected by the epidemic.
Box 1.1. Global financing architecture for the HIV response

Globally, the major sources of financing for HIV programmes at the end of 2008 (the last year for which updated data are available) were domestic expenditures in the affected countries, which accounted for 52% of all investments, followed by direct bilateral cooperation (31%), multilateral institutions (12%) and the philanthropic sector (5%) (8).

After years of considerable increases in international assistance from high-income countries for the global HIV response, funding remained essentially flat over the 2008-2009 period. According to recent estimates, commitments from donor governments totalled US$ 8.7 billion, the same as in 2008 (9). In comparison, it has been estimated that US$ 26.7 billion would have been necessary – from all sources, including domestic and international – for the global HIV response in low- and middle-income countries in 2010 (8).

Global initiatives and multilateral institutions, including the Global Fund to Fight AIDS Tuberculosis and Malaria, the World Bank and, more recently, UNITAID, continue to be important mechanisms for financing the scale-up of HIV interventions. Since its founding in 2002, the Global Fund has committed more than US$ 11 billion to finance HIV-related programmes in 140 countries. In 2009, it approved its ninth round of funding, which allocated an additional US$ 1.86 billion to HIV proposals in 36 countries. The World Bank, in addition to its financing role, has ramped up significantly the provision of technical support to national partners. Since 1989, overall HIV-related commitments to all regions have totalled US$ 4.2 billion (10). UNITAID has also consolidated its role as a key contributor to scaling up access to medicines and diagnostics for HIV, malaria and TB. UNITAID has raised over US$ 1 billion since its launch in 2006 and, by December 2009, had committed over US$ 565 million to four HIV/AIDS project areas in 51 countries (11).

Bilateral aid flows remain a major source of funding for HIV programmes in low- and middle-income countries. The United States, through the United States President’s Emergency Plan for AIDS Relief (PEPFAR), is the largest individual provider of funding for the scale-up of HIV/AIDS services worldwide. Annual commitments channelled through its bilateral programmes rose from US$ 1.65 billion in 2004 to US$ 5.5 billion in 2009. For 2010, an additional US$ 5.5 billion investment has been enacted.

In addition to bilateral and multilateral sources, private foundations, such as the Bill & Melinda Gates Foundation and the William J. Clinton Foundation, have also contributed significantly to the global AIDS response over the past several years, both financially and technically. The Bill & Melinda Gates Foundation is the single largest source of private development assistance for health, with annual commitments reaching nearly US$ 2 billion in both 2006 and 2007 (8,12).

1 This figure does not include the additional investments required to expand coverage of antiretroviral therapy to meet the new treatment eligibility criteria recommended by WHO (see chapter 4 for more details).

1.1. Data sources and methods

WHO, UNICEF and UNAIDS jointly collected data from national programmes worldwide through a common reporting tool to monitor and report on progress in the health sector response towards universal access. In order to avoid duplication and maximize data consistency, all indicators and the corresponding data collection processes have been designed to build on the monitoring framework of the Declaration of Commitment on HIV/AIDS of the United Nations General Assembly Special Session (UNGASS) on HIV/AIDS (7). However, this report differs from its 2009 version in two main aspects. First, this year, countries were asked to report data on 35 indicators, compared to 46 in 2009 (see Annex 8). Second, not all 35 indicators are presented and discussed in this report, as a number of them will be compiled and published later this year in the AIDS Today: 2010 UNAIDS Global Report. Data used in this report were reported by 39 high-income and 144 low- and middle-income countries. In addition, estimates of treatment needs and coverage in low- and middle-income countries have been substantially revised due to changes in the recommended set of criteria for therapy initiation. WHO’s 2010 antiretroviral therapy guidelines now recommend that all adults and adolescents, including pregnant women, with HIV infection and a CD4 count of or below 350 cells/mm³ should be started on antiretroviral therapy, regardless of whether or not they have clinical symptoms. This change increased the number of people estimated to be in need of antiretroviral therapy at the end of 2009 from 10.1 million to 14.6 million [13.5 million-15.8 million] (see Box 4.2).

The data collected encompass the following programmatic areas: (i) HIV testing and counselling, (ii) prevention of sexual transmission of HIV and prevention of transmission through injecting drug use, (iii) management of sexually transmitted infections; (iv) coverage of antiretroviral therapy (v) coverage of collaborative HIV/TB services, (vi) stock-outs of antiretroviral drugs, and (vii) HIV interventions for women and children, including prevention of mother-to-child transmission. Policy-related questions were also asked to assess programmatic development. Response rates varied by indicator and are presented in the corresponding chapters.
Box 1.2. Measuring progress towards universal access

In order to adequately gauge programmatic success, it is critical to properly agree on a standard set of definitions and concepts. Throughout this report, “access” is understood as a broad concept that measures three dimensions of key health sector interventions: availability, coverage, and outcome and impact.

Availability is defined in terms of the reachability (physical access), affordability (economic access) and acceptability (sociocultural access) of services that meet a minimum standard of quality. Making services available, affordable and acceptable is an essential precondition for achieving universal access.

Coverage is defined as the proportion of people needing an intervention who receive it. Coverage is influenced by the supply or provision of services, and by the demand from those who need services and their health-seeking behaviour.

Outcome and impact are defined in terms of medium-term effects, such as behavioural change or higher survival rates, and long-term effects, such as lower infection rates. Outcome and impact are the result of coverage, and depend on the efficiency and effectiveness of interventions.

This report also relies on data from other sources, including special surveys (such as on pricing and utilization of antiretroviral drugs and other supplies, and surveillance of HIV drug resistance), population-based surveys (such as the Demographic and Health Surveys) and recent scientific literature. Additional data- and methodology-related notes are included in each chapter, as appropriate.

1.2. Structure of the report

This report is structured as follows:

Chapter 1 (Introduction) outlines the objectives of the report and the methods used to track progress towards universal access.

Chapter 2 presents the global progress in expanding availability and uptake of HIV testing and counselling.

Chapter 3 discusses progress in scaling up health sector interventions for HIV prevention, including for key populations at higher risk for HIV infection.

Chapter 4 presents global progress in scaling up access to treatment and care for people living with HIV.

Chapter 5 presents global progress towards scaling up HIV services for women and children, including interventions to prevent mother-to-child transmission of HIV.

Chapter 6 identifies the main challenges and the way forward towards achieving international goals.

The statistical annexes provide country-specific data on facilities and services for testing and counselling and for sexually transmitted infections and on the global coverage of antiretroviral therapy and services to prevent mother-to-child transmission. Additional notes on data sources and methods are also provided.


