Towards Universal Access

Scaling up priority HIV/AIDS interventions in the health sector

Progress Report 2008
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TOWARDS UNIVERSAL ACCESS

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# TABLE OF CONTENTS

Foreword  5

Executive summary  7

1. Introduction  9
   1.1 Background  9
   1.2 Data sources and methods  11
   1.3 Structure of the report  12

2. Treatment and care for people living with HIV  15
   2.1 Antiretroviral therapy  16
      2.1.1 Global coverage of antiretroviral therapy  16
      2.1.2 Expanding the availability of antiretroviral therapy  20
      2.1.3 Equity in access to antiretroviral therapy  22
      2.1.4 Impact and outcomes of scaling up antiretroviral therapy  26
      2.1.5 Prevention and assessment of HIV drug resistance  27
      2.1.6 Antiretroviral drug regimens  28
      2.1.7 Antiretroviral drug prices  32
      2.1.8 Laboratory services  35
   2.2 Care and management of HIV/TB coinfection and other types of comorbidity  36
      2.2.1 Responding to the dual epidemic of HIV and TB  36
      2.2.2 HIV and viral hepatitis  43
      2.2.3 HIV and other comorbidity  43

3. HIV testing and counselling  49
   3.1 Global availability and coverage of HIV testing and counselling  50
   3.2 Provision of HIV testing and counselling  55
   3.3 Scaling up provider-initiated HIV testing and counselling  56
   3.4 Diversifying approaches to scale up HIV testing and counselling  59
   3.5 Addressing concerns related to HIV testing and counselling practice  60

4. Health sector interventions for HIV prevention  63
   4.1 Preventing HIV infection among the population groups most at risk  64
      4.1.1 Sex workers and their clients  64
      4.1.2 Injecting drug users  66
      4.1.3 Men who have sex with men  68
      4.1.4 Prisoners  69
   4.2 Prevention and care for people living with HIV  71
   4.3 Male circumcision  72
   4.4 Preventing HIV transmission in health care settings  73
5. Scaling up HIV services for women and children

5.1 Primary prevention of HIV for women of childbearing age
5.2 Preventing unintended pregnancies among women living with HIV
5.3 Preventing the vertical transmission of HIV from mother to child
  5.3.1 HIV testing and counselling
  5.3.2 Antiretrovirals for preventing mother-to-child transmission
  5.3.3 Antiretroviral regimens
  5.3.4 Infant feeding
5.4 Treatment, care and support for women living with HIV and their children
  5.4.1 Increasing access to antiretroviral therapy for pregnant women
  5.4.2 Diagnosing HIV among infants
  5.4.3 Co-trimoxazole prophylaxis
  5.4.4 Antiretroviral therapy for children

6. Strengthening health systems and health information

6.1 Strengthening health systems
6.2 Integrating HIV services with primary health care
6.3 Investing in health information

7. Towards universal access: the way forward

Statistical annexes

Annex 1 Estimated numbers of people receiving and needing antiretroviral therapy and coverage percentages
Annex 2 Reported numbers of people receiving antiretroviral therapy in low- and middle-income countries by sex and by age
Annex 3 Preventing mother-to-child transmission of HIV in low- and middle-income countries
Annex 4 Estimated numbers of people receiving and needing antiretroviral therapy and antiretrovirals for preventing mother-to-child transmission and coverage percentages in low- and middle-income countries by WHO and UNICEF regions
Classification of low- and middle-income countries by income level, epidemic level and geographical, UNAIDS, UNICEF and WHO regions
Explanatory notes
FOREWORD

Two years ago at the United Nations General Assembly High-Level Meeting on AIDS, countries committed to reaching as close as possible to the goal of universal access to HIV prevention, treatment, care and support by 2010. In this report, as we approach 2010, we assess how far we have come. Progress in the health sector is a key measure of progress towards universal access. This second annual report on the global health-sector response to HIV reveals impressive achievements as well as ongoing challenges in meeting our goals.

Increased political commitment and allocation of resources are having an effect in the most severely burdened countries. By the end of 2007, nearly 1 million more people were receiving antiretroviral therapy than in 2006, and the world had met the “3 by 5” target of providing antiretroviral therapy to 3 million people in low- and middle-income countries – a target many people predicted was unachievable when the initiative was launched in 2003. With the unprecedented scale-up of treatment, people living with HIV are living longer and have a better quality of life.

The report also documents encouraging trends in providing health services targeting women and children. More mothers have access to interventions to prevent transmission to their infants, and more children living with HIV are benefiting from treatment and care programmes.

Despite this progress, much remains to be done. As we look ahead, it is clear that – even at the increased pace of scale-up – most countries will not meet the goal of universal access by 2010. Most people living with HIV remain unaware of their HIV status. As many as 6800 people are newly infected with HIV every day because of poor access to affordable, proven interventions to prevent HIV transmission, yet only about 2700 additional people receive antiretroviral therapy per day. The HIV/TB co-epidemic, one of the most serious consequences of the spread of HIV, has been further complicated by the emergence of multidrug-resistant and extensively drug-resistant TB. Despite the substantial progress in access to treatment, more than two thirds of people in need are being left behind, while still others are being lost to follow-up after initiating treatment.

Three challenges require urgent and concrete action: ensuring the sustainability of the response; building stronger health systems; and generating high-quality strategic information. To sustain our efforts, we need more financial and technical resources over the long term to maintain people on treatment and prevent new HIV infections. Countries require strong health systems and skilled human resources to deliver services. Expanding HIV programmes represents an opportunity to promote innovative models of integrating HIV interventions into the primary health care system and to strengthen the health system as a whole, including its infrastructure and laboratory capacity. Finally, countries need information to monitor their achievements and improve outcomes. “What gets measured gets done.”

By committing to universal access, the international community has embarked on an ambitious, long-term commitment to reducing new infections, disease and mortality. The challenges ahead are daunting, but our collective efforts are showing positive results. Together, we have an opportunity to turn one of the greatest public health initiatives in history into a lasting public health success.

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EXECUTIVE SUMMARY

The main messages of this report are the following.

- The combined efforts of countries and international partners have resulted in substantial, ongoing progress towards providing HIV interventions in low- and middle-income countries.

- Access to antiretroviral therapy for advanced HIV infection is increasing at an accelerating pace in low-and middle-income countries. About 3 million people (2,700,000–3,280,000 people) were receiving antiretroviral therapy at the end of 2007, nearly 950,000 more compared with the end of 2006 and a 7.5-fold increase during the past four years.

- Despite progress, antiretroviral therapy coverage remains low: only 31% [27–34%] of people in need were receiving antiretroviral therapy in 2007. That same year, an estimated 2.5 million people were newly infected with HIV.

- Estimates of need and coverage are derived from statistical models. The parameters used for estimating need and coverage in 2007 differ from those used in previous years due to improvements in methods. For this reason, comparing the estimates of need and coverage published in this report with those published in previous progress reports is inappropriate.

- The decreases in mortality and morbidity rates among people receiving antiretroviral therapy in low- and middle-income countries are comparable to those in high-income countries. However, many countries still face significant challenges. These include higher mortality in the six months following the initiation of treatment, and insufficient retention rates.

- Tuberculosis continues to be the leading cause of death among people living with HIV. Access to interventions for people living with HIV/TB is falling short because many people with TB do not know their HIV status. Rates of coinfection with hepatitis B and C viruses are high, especially among injecting drug users. The prevalence of hepatitis C virus among injecting drug users living with HIV has been estimated to range between 72% and 95% in some countries.

- Countries are increasingly relying on diverse client- and provider-initiated strategies to expand knowledge of HIV status. The availability of HIV testing and counselling in health facilities increased substantially between 2006 and 2007 in countries with comparable data, accompanied by an increase in the number of people who received HIV testing and counselling. However, a large majority of the people living with HIV remain undiagnosed and are lacking opportunities to access adequate prevention, treatment, care and support services.

- Successful examples of HIV prevention among high-risk populations such as sex workers and their clients, injecting drug users, men who have sex with men and prisoners, have been implemented in multiple settings. Further efforts are needed to scale up access to prevention interventions, to strengthen surveillance and monitoring and to ensure that policies and legislation create an environment that encourages the effective delivery of health services.

- Research has now unequivocally demonstrated that male circumcision is an important additional health sector intervention that reduces the risk of heterosexually acquired HIV infection among men by 60%. Many countries in sub-Saharan Africa with high rates of HIV transmission and low rates of male circumcision are exploring whether, and how, to scale up male circumcision. However, research exploring alternative prevention technologies has yielded mixed results. Trials of female microbicides, preventive vaccines and suppression of herpes simplex virus genital infections have failed to show efficacy.

- There has been substantial progress in scaling up access to services for the prevention of mother-to-child transmission. A growing number of pregnant women living with HIV have access to HIV testing and counselling services and are receiving antiretroviral drugs to prevent transmission to their children. In 2007, 33% of pregnant women living with HIV in low- and middle-income countries received antiretroviral drugs to prevent transmission to their children versus 10% in 2004. However, only 12% of pregnant women living with HIV identified during antenatal care were assessed for their eligibility to receive antiretroviral therapy for their own health.

- Today, more children are accessing care and treatment services than in previous years. In 2007, nearly 200,000 children with HIV in low- and middle-income countries received antiretroviral therapy versus 127,000 in 2006. However, the difficulty of diagnosing HIV early among infants remains an obstacle to further gains.

- Despite substantial progress in 2007, most low- and middle-income countries are still far from achieving universal access goals. Obstacles include weak health care systems, a critical shortage of human resources and a lack of sustainable, long-term funding. Countries also require monitoring systems to track progress and increase the effectiveness and impact of HIV programmes.
1. INTRODUCTION

Tracking progress in the health sector towards achieving universal access

The objective of this report is to monitor global progress in the health sector as it scales up HIV prevention, treatment and care interventions towards universal access (1,2).

The current report is the second in a series of annual progress reports developed by the World Health Organization (WHO), the Joint United Nations Programme on HIV/AIDS (UNAIDS) and the United Nations Children’s Fund (UNICEF) in partnership with other international monitoring and reporting mechanisms to monitor the response of the health sector to HIV. It follows the 2007 progress report (3) and previous “3 by 5” reports that charted the scaling up of antiretroviral therapy (4–7).

This report includes a focus on women and children. It incorporates data collected by UNICEF and WHO on behalf of the Expanded Interagency Task Team on Prevention of HIV Infection in Pregnant Women, Mothers and their Children (8).

Although all sectors of society have important contributions to make in achieving universal access targets, the health sector plays a key role in the response to the epidemic. The health sector is wide-ranging and includes: organized public and private health services (including those for health promotion, disease prevention, diagnosis, treatment and care); health ministries; nongovernmental organizations; community groups; professional associations; as well as institutions that directly input into the health care system, such as the pharmaceutical industry and teaching institutions (9). Recent estimates indicate that the health sector alone represents at least 55% of the resources required for the global response to HIV/AIDS (10).

The report reviews progress in the following areas:

- treatment and care for people living with HIV: antiretroviral therapy, care and management of HIV/TB coinfection and other comorbidity;
- HIV testing and counselling;
- health sector interventions to prevent sexual transmission, transmission through injecting drug use, mother-to-child transmission and transmission in health care settings; and
- health systems and HIV: human resources, drug procurement and supply management and health information.

Each of these health-sector interventions represents a key area in which countries must invest to achieve universal access to HIV prevention, treatment, care and support.

1.1 Background

By the end of 2007, an estimated 33.2 million [30.6 million–36.1 million] people were living with HIV, of whom 2.1 million [1.9 million–2.4 million] were children. An estimated 2.5 million [1.8 million–4.1 million] people were newly infected in 2007, and 2.1 million [1.9 million–2.4 million] died from AIDS. About two thirds of all people with HIV live in sub-Saharan Africa (11).

The international community has intensified its commitment and efforts to address the HIV epidemic in recent years. In 2001, the United Nations convened a special session on HIV/AIDS and, for the first time in history, agreed to a set of global targets in response to a rapidly escalating global public health crisis (12). In 2006, at the second United Nations General Assembly High Level Meeting on HIV/AIDS, countries agreed to work towards the goal of “universal access to comprehensive prevention programmes, treatment, care and support” by 2010 (2). These global commitments complement the health-related United Nations Millennium Development Goals (13), which established targets to reduce child mortality, improve maternal health and combat HIV/AIDS, malaria and other major diseases by 2015.

Although recent epidemiological estimates remain a daunting obstacle to progress, increased global political commitment and financial investment are having a positive impact. Increasing numbers of people have access to HIV prevention, treatment, care and other interventions. Expanded access to antiretroviral therapy has reduced morbidity and mortality to an extent discernible at a population level, and evidence is mounting that prevention programmes are resulting in behaviour change and declining HIV prevalence in several high-burden countries (11).

However, although significant resources have been allocated to the HIV response in recent years (Box 1.1), evidence indicates that many countries are far from achieving universal access goals. Countries continue to face a number of challenges in expanding and sustaining the response to HIV. These include weak health systems, a critical shortage of human resources and lack of long-term sustained financing.

At the end of 2007, the annual gap between the required and available financial resources necessary to achieve universal access goals was estimated to be US$ 8.1 billion. To meet targets, available financial resources must more than quadruple by 2010 from the 2007 level – up to about US$ 35 billion. Projections reveal that funding would need to increase to US$ 41 billion by 2015 (10).

1 Updated estimates will be published in mid-2008.
2 The figures presented in this report have been adjusted to take into account the revised global estimates in the HIV epidemic after September 2007.
Box 1.1. Global AIDS funding architecture

Political commitment to scale up the response to HIV has been accompanied by increased allocation of financial resources made available through an evolving global funding architecture.

Domestic funding
Domestic resources cover a significant proportion of the cost of scaling up towards universal access. National health care funding could supply roughly one third of the amount necessary to close the gap between the required and available resources. External sources will be required to cover the remaining two thirds (10).

Multilateral funding
Multilateral organizations have increased their HIV investment during the past several years. The Global Fund to Fight AIDS, Tuberculosis and Malaria currently provides 20% of all funding for the response to HIV/AIDS (14). It has continued to expand grants allocated for HIV prevention, treatment and care programmes and succeeded in securing commitments for increased investment from donor countries in 2007.

The World Bank has committed about US$ 2 billion through grants, loans and credits for programmes for the response to HIV/AIDS since 2001. The Bank’s Multi-Country HIV/AIDS Program for Africa (15), launched in September 2000, has committed US$ 1.2 billion to 29 countries for the response to HIV/AIDS.

UNITAID, an international drug purchasing facility launched in 2006, provides sustainable, long-term funding for HIV/AIDS, tuberculosis (TB) and malaria drugs and diagnostics. UNITAID is financed primarily from the proceeds of a tax on airline tickets. The budget of UNITAID exceeded US$ 320 million in 2007 and included funding for the purchase of antiretroviral medicine for children, second-line antiretroviral medicines and drugs and diagnostics to prevent transmission from mother-to-child (16).

Bilateral funding

The United States is the largest donor, contributing more than half of total bilateral aid to HIV in 2006 primarily via the United States President’s Emergency Plan for AIDS Relief. The Plan, the world’s largest bilateral AIDS programme, has been submitted to the United States Congress for reauthorization along with a request to more than double funding – to between US$ 37 billion and US$ 41 billion – over the next five years. Other major bilateral funding sources include the United Kingdom, whose share in the total represents 12%; and Canada, France, Germany, the Netherlands and Sweden, whose contributions together represent another 20% of the total contribution from members of the Development Action Committee.

Sub-Saharan Africa accounted for 57% of total bilateral aid flows for controlling HIV/AIDS in 2004–2005. The top 10 aid recipients were the United Republic of Tanzania, South Africa, Uganda, India, Kenya, Zambia, Ethiopia, Mozambique, the Democratic Republic of the Congo and Nigeria.

Private-sector funding
Private foundations such as the Bill & Melinda Gates Foundation and the William J. Clinton Foundation have also contributed significantly to the response to HIV/AIDS over the past several years.

3 The members of the Development Action Committee are: Australia, Austria, Belgium, Canada, Denmark, Finland, France, Germany, Greece, Italy, Ireland, Japan, Luxembourg, the Netherlands, New Zealand, Norway, Portugal, Spain, Sweden, Switzerland, the United Kingdom, the United States and the Commission of European Communities.
1.2 Data sources and methods

This report has several sources of information. The first is the framework developed by WHO to monitor progress in the health sector as it scales up towards universal access (18). The framework includes 39 indicators designed to measure the availability, coverage and impact of high-priority HIV interventions delivered by the health sector. The framework is also used to monitor key health system components required to support scale-up, including procurement, supply management and human resources. WHO collected data from countries through a questionnaire based on the framework (Box 1.2).

The second source of information is the Report Card on Prevention of Mother-To-Child Transmission of HIV and Paediatric HIV Care and Treatment in Low- and Middle-income Countries, issued jointly by UNICEF and WHO on behalf of the Expanded Interagency Task Team on Prevention of HIV Infection in Pregnant Women, Mothers and their Children. The Report Card includes a set of indicators for monitoring the progress of national programmes to prevent HIV infection among infants and young children (8).

Both reporting tools have shared indicators that were developed in coordination with the reporting process for the United Nations General Assembly Special Session on HIV/AIDS to harmonize data collection at the country level. UNAIDS, UNICEF, WHO and other partners work with national governments to include these indicators in national monitoring systems.

At the country level, health ministries administer data collection in collaboration with the country offices of WHO, UNICEF and other implementing partners. Aggregate data at the global level are cross-validated and reconciled with data collected by international partners, including bilateral and multilateral organizations (see explanatory notes to statistical annexes).

Data collected through UNAIDS, UNICEF and WHO are supplemented by data from other surveys (such as on drug pricing and utilization and surveillance of drug resistance), more detailed population-based surveys (21), special studies and grey literature. The report also presents relevant evidence from recent scientific literature.

Box 1.2. Monitoring progress towards universal access

In defining “universal access”, WHO, UNAIDS and their partners recognize that even high-income countries with well-developed infrastructure have difficulty in reaching 100% of the people who need interventions. As recently as 2005, only 55% of the people who needed antiretroviral therapy in the United States received it (19).

“Access” is 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 universal access.
- Coverage is defined as the proportion of the people needing an intervention who receive it. Coverage is influenced by supply (provision of services) and by the demand from those who need services.
- Outcome and impact are defined in terms of behavioural change, lower infection rates or higher survival rates. Outcome and impact are the result of coverage, modulated by the efficiency and effectiveness of interventions.

In addition to the availability, coverage and outcome and impact of interventions, other aspects also determine the attainment of universal access, including whether the services are provided in an equitable manner and their quality, acceptability and effectiveness.

The data on the coverage of antiretroviral therapy and services for preventing mother-to-child transmission presented in this report cannot be compared with the data published in previous reports (3–7) owing to a change in the methods used to estimate the need. Sections 2 (Box 2.1) and 5 (Box 5.6) provide more details.

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4 “Access”, “utilization”, “availability” and “coverage” are often used interchangeably to indicate whether people who need something for their health are actually getting it (20).
1.3 Structure of the report

The report is structured as follows.

Section 1 outlines the objectives of the report and the methods and definitions used to track progress towards universal access.

Section 2 presents global progress towards scaling up access to treatment and care for people living with HIV.

Section 3 presents global progress towards scaling up HIV testing and counselling.

Section 4 presents global progress towards scaling up health sector interventions for HIV prevention.

Section 5 presents global progress towards scaling up HIV services for women and children, including those aimed at preventing mother-to-child transmission.

Section 6 summarizes available information on strengthening health systems and investing in strategic information aimed at guiding the response.

Section 7 identifies the main challenges and the way forward.

The statistical annexes contain detailed tables outlining the global coverage of antiretroviral therapy and prevention of mother-to-child transmission.
References


