FREQUENTLY ASKED QUESTIONS (FAQ)

TOWARDS UNIVERSAL ACCESS

Scaling up priority HIV/AIDS interventions in the health sector

JUNE 2008 PROGRESS REPORT

Q. What is the purpose of this report?

A. *Towards Universal Access: Scaling up Priority HIV/AIDS interventions in the health sector* is the second in a series of annual progress reports developed by WHO, UNAIDS and UNICEF to monitor the health sector response to HIV/AIDS. This report builds on the 2007 report on the health sector response towards universal access, as well as on previous '3 by 5' progress reports on the scale-up of antiretroviral therapy.

The report documents health sector progress in scaling up priority HIV prevention, treatment and care interventions towards universal access, including:

- Treatment and care, including antiretroviral therapy (ART), management of HIV/TB co-infection and other co-morbidities;
- HIV testing and counselling;
- Prevention of mother-to-child transmission (PMTCT), in health care settings, and of sexual HIV transmission and transmission through injecting drug use;
- Health systems issues, including drug procurement and supply management, human resources and health information.

This report also includes a special focus on scaling up HIV interventions for women and children.

Q. How has access to HIV prevention, treatment and care improved?

A. The report finds that access to antiretroviral therapy, testing and counselling, and services to prevent mother-to-child transmission of HIV all increased significantly in 2007 in low- and middle-income countries due to increasing national commitment, financial investment, and technical guidance and support through multilateral, bilateral and private sector initiatives. Specifically:

- Approximately 3 million people in low- and middle-income countries were receiving HIV antiretroviral therapy at the end of 2007.
- Progress in providing access to ARVs (antiretrovirals) is accelerating, with nearly one million more people receiving ARVs by the end of 2007, compared to the end of 2006. In previous years the corresponding annual increases were approximately 700 000.
- Sites providing ARVs more than doubled between 2005 and 2007 (4 000 to 10 000).
- Prices for most first-line ARVs dropped from between 10% and 40% between 2006 and 2007.
- The availability of HIV testing and counselling, a critical entry point to both treatment and prevention, increased substantially between 2006 and 2007 in 12 countries reporting comparable data, accompanied by an increased uptake.
- About 33% of pregnant women received ARVs to prevent HIV transmission in childbirth in 2007, up from 10% in 2004. An estimated 18% of pregnant women received an HIV test in 2007—up from 10% in 2004.

Q. What are the report's key findings regarding access for women and children?

A. Access to prevention, treatment, care and support is particularly important for women and girls owing to their increased vulnerability to HIV infection, and the impact that HIV has on women and girls. Women represent approximately half of people living with HIV worldwide and more than 60% of people living with HIV in sub-Saharan Africa. The report finds that, overall, women enjoy access to ARVs that is greater than, or equal to, that of men. However, only 12% of HIV-positive pregnant women were assessed to see if they needed ARVs for their own health, even though we would expect that many more HIV-positive pregnant women are likely to have advanced disease.

An estimated 2.1 million children under the age of 15 years are living with HIV. Increasing numbers of children are benefiting from paediatric antiretroviral therapy due to falling drug prices, new fixed-dose combinations, and improving integration of paediatric treatment into maternal, newborn and child health services. The number of children receiving treatment increased from approximately 75 000 in 2005 to approximately 200 000 in 2007, an increase of more than 150%.

One major barrier to expanded treatment coverage for children is the fact that only 8% of infants born to HIV-positive mothers in 2007 in those countries where data were available were tested within the first 2 months following birth.

Q. How close do these gains bring nations to the universal access to treatment goal?

A. At the end of 2007, 21 low- and middle income countries provided treatment to more than 50% of those in need. Of these, 9 reached a coverage of at least 75% (Bhutan, Botswana, Brazil, Chile, Costa Rica, Cuba, Georgia, Lao People Democratic Republic, Namibia). Most, however, remain far from the goal, despite significant improvements in many areas. Nearly one million more people were receiving antiretroviral therapy at the end of 2007, as compared to 2006. That same year, however, 2.5 million people were newly infected with HIV.

Q. What obstacles to achieving the universal access goal are identified in the report?

A. Obstacles to rapid and effective scale-up identified in the report include weak health systems, including a critical shortage of human resources; the lack of reliable, sustainable, long-term financing for prevention and treatment scale-up; and weak information systems. The report calls for increased resources, sustained political commitment, improved stakeholder coordination and additional research to address these challenges.

Programmatic obstacles also include: poor knowledge of HIV status; late initiation of ART and low rates of patient retention in treatment programs; inadequate outreach to at-risk populations and those individuals living in rural areas; the high cost of second-line regimens; lack of capacity for infant diagnosis; and weak linkages with other services including tuberculosis control and maternal and infant health programmes.

Q. What resources have been allocated to this effort, and what resources are needed for the future?

A. By the end of 2007, an estimated US$ 10 billion was available for HIV response—an almost forty-fold increase since 1996. To meet the goal of universal access by 2010, available resources for HIV must increase to about US$ 35 billion by 2010 and to US$ 41 billion by 2015.

Q. What does the report say about the effectiveness of ARV therapy in low- and middle- income countries?

A. The report finds that improvements in patient health and rates of patient adherence to ARV therapy are comparable between low-, middle- and high-income countries. However, the report also finds that some benefit of ARV therapy is lost in low- and middle-income countries due to late diagnosis of people with HIV and, therefore, late initiation of therapy with consequent high mortality. Improving timely diagnosis of HIV infection and efforts to begin ARV therapy in a timely manner are key. Increased attention is also required to ensure consistent and long term follow-up.

Moreover, many patients living in low- and middle income countries continue to face difficulties adhering to long-term treatment owing to both structural factors (such as user fees, distance to health facilities, stigma) as well as individual factors (treatment side-effects and co-morbidities).

Q. What does "universal access" mean?

A. WHO and UNIADS estimate that 9.7 million people currently need antiretroviral therapy in low- and middle-income countries.

In June 2006, the United Nations General Assembly adopted a resolution calling for scaling up HIV prevention, treatment, care and support with the aim of achieving Universal Access to treatment by 2010 for all who need it. For most interventions, no global targets have been defined. For ART, the target of 80% is sometimes proposed, but even in wealthy nations this is often not achieved.

Defining universal access is complex as needs are continuously evolving due to trends in the epidemic, new evidence about survival with and without ART, and updated recommendations for initiating treatments. WHO and UNAIDS estimate at 9.7 million (8.7-11.0) the number of people currently needing ART in low and middle income countries.

According to the report, scaling up services must include efforts to ensure the:
- Availability of services, meaning that services are physically accessible, affordable and acceptable to the people who need them.
- Coverage of services, or the proportion of a population needing an intervention who receive it. Coverage is influenced both by the supply of and demand for services.
- Outcome and impact of services, including behavioural change, reduced new infection rates, and improvements in patient survival.

Q. Is the universal access goal achievable?

A. Universal access to HIV prevention, treatment, care and support is not only achievable, it is a public health and human rights imperative, which has been agreed to by the United Nations member states and international donors. Many nations will meet specific universal access targets (such as PMTCT or ART) by 2010, while many others will meet them in 2011, 2012, and/or subsequent years. The focus of WHO, UNAIDS and others is to ensure that all states meet the goal as early as possible.

Q. How does WHO help countries achieve the universal access goal?

A. Within the UNAIDS family, WHO leads the health sector response. WHO works with countries to develop standards for HIV prevention, treatment and care, develop service delivery systems, and monitor and report on progress towards and obstacles to achieving universal access to HIV services.

Q. What are the data sources for the report?

A. This report presents data relating to the health sector response to HIV/AIDS in low- and middle-income countries, as well as data on antiretroviral therapy coverage from high-income countries. There are several sources of information for this report:

The WHO framework to monitor health sector progress towards universal access, which includes 39 indicators to measure the availability, coverage and impact of priority HIV interventions delivered by the health sector. The framework is also used to monitor progress in strengthening key components of the health system required to support scale-up, including procurement and supply management and human resources.

The Report Card on Prevention of Mother-To-Child Transmission and Paediatric HIV Care, issued jointly by UNICEF and WHO on behalf of the Interagency Task Team on Preventing HIV Infection in Pregnant Women, Mothers and their Children. The Report Card includes a set of indicators to monitor progress in national programmes to prevent HIV infection in infants and young children.

Questionnaires ask national governments to provide annual quantitative and qualitative data on HIV interventions, as well as information on national programmes and policies and challenges in programme implementation. UNAIDS, UNICEF, WHO and other partners work with national governments to include these indicators in national monitoring systems.

Data collected through the UNAIDS, UNICEF and WHO reporting tools are supplemented by data from other surveys (e.g., on drug pricing and utilization, surveillance of drug resistance), more detailed population-based data provided by Demographic and Health Surveys , special studies and grey literature. The report also presents relevant evidence from recent scientific literature.

These data present the best-available snapshot of a complex, fast-developing multi-national effort to scale up a range of HIV health services, using the best available information and statistical methodologies.

Q. How are data validated?

A. Ministries of health work with country offices of WHO, UNICEF and other implementing partners to review and validate these data. Global-level data are cross-validated and reconciled with data collected by international partners, including bilateral and multilateral organizations which have committed to reporting on these indicators such as the Global Fund to Fight AIDS, Tuberculosis and Malaria, and the President's Emergency Plan for AIDS Relief (PEPFAR). Ranges are provided to acknowledge the possible uncertainty in the estimates given.

Q. Can data be compared to those in earlier reports?

A. Data regarding needs and coverage of antiretroviral therapy and the prevention of mother-to-child transmission in this report cannot be compared directly to data published in previous reports, due to new parameters in the methodology to estimate the need for these interventions. More details on estimating need and coverage are provided in Sections 2 and 5.

Q. Is HIV treatment having a demonstrable impact on mortality?

A. The UNAIDS/WHO Epidemiological Update reports decreases in the global number of deaths from 2005 to 2007. Researchers attribute this decline to the increasing availability of ART. Research and several recent special studies have also shown reduced mortality in specific populations or cohorts.

Q. What is being done to reduce the number of people dying in the early months of treatment, or are those who are lost to follow-up?

A. WHO and partners are working on developing and establishing better patient tracking systems. Early diagnosis and referral to treatment is critical to decreasing death rates and maximizing the impact of ARV therapy for people living with HIV/AIDS. Early diagnosis requires continued, ongoing expansion of access to HIV testing and counselling. While the availability and uptake of HIV testing and counselling increased substantially between 2006 and 2007 in 12 countries reporting comparable data, recent population-based surveys indicate that only about 20% of people living with HIV/AIDS knew their HIV status.

Only about 7% of men and women in low- and middle-income countries had an HIV test between 2006 and 2007. Diagnosis of HIV in the late disease stage greatly reduces the effectiveness of ARV therapy.

Health systems must also be strengthened to increase the availability and acceptability of ARV therapy and increase the number of patients who start and remain on therapy. Patient monitoring systems must also improve, in order to improve identification of and outreach to patients who have stopped receiving therapy.

Q. What is meant by a 'public health approach' to scaling up treatment?

A. The public health approach is a WHO strategy that seeks to greatly expand ARV access by emphasizing the principles of simplification, standardization, decentralization, equity, and patient and community participation. The approach utilizes standardized regimens and simplified formularies, along with simplified clinical decision-making and standardized treatment monitoring. This approach seeks to provide the best quality of care for the

largest number of people, recognizing the financial and human resource constraints facing many developing world health systems.

Q. Should there be a greater emphasis on achieving universal access to prevention?

A. HIV prevention and treatment must be strengthened in tandem. Just as there is considerable progress to be made in providing access to treatment and care, access to effective HIV prevention services must also greatly increase to meet the universal access goal. The number of new HIV infections (an estimated 2.5 million in 2007) must decrease dramatically before we can begin to effectively reduce the epidemic and treat all those who need it. Without more effective prevention, it will become ever more difficult to assure treatment for all who need it.

Q. What does WHO do to help ensure the quality of ARV regimens in low- and middle- income countries?

A. WHO's Pre-qualification Programme evaluates and inspects priority medicines and helps build and strengthen national capacity for manufacturing and monitoring quality medicines. In 2007 WHO pre-qualified 13 new antiretroviral formulations. WHO also conducts quality assurance surveys of antiretrovirals to ensure that patients in low- and middle-income countries receive quality medicines.

Q. Why is the integration of HIV with TB programming so important?

A. Tuberculosis (TB) remains among the leading causes of HIV-related morbidity and mortality. The emergence of multi-drug-resistant TB (MDR-TB) and extensively drug resistant TB (XDR-TB) poses a significant public health threat, particularly for countries with high HIV prevalence.

Q. What progress is being made to control HIV and TB?

A. Remarkable progress has been made in each of these areas in many of the 63 HIV/TB priority countries identified and surveyed by WHO between 2000 and 2006. Noteworthy increases in HIV testing and counselling of TB patients have been reported in some high HIV/TB burden African countries, as well as in some countries is Asia.

In 2006, co-trimoxazole prophylaxis (CTXp) was provided to 78% of the HIV-positive TB patients (147 000) identified through testing, 2.5 times the rate of CTXp access in 2005. Globally, around 67 000 HIV-positive TB patients began antiretroviral therapy in 2006, more than double the number enrolled in 2005. Overall, 41% percent of diagnosed HIV-positive TB patients were enrolled on antiretroviral therapy.

Coverage of HIV testing and counselling for people living with TB remains insufficient, however. Only 12% of notified TB cases globally and 22% of notified TB cases in the African Region received HIV testing and counselling in 2006. The continuing large numbers of people who have gone untested represents a significant missed opportunity to provide prevention, care and treatment.

Q. What is WHO doing to treat people who are co-infected with HIV/TB?

A. WHO is working closely with national HIV and TB programmes to promote improved responses to these dual epidemics through increased collaboration between HIV and TB programmes; introduction of isoniazid preventive therapy; improved tuberculosis infection control; and increased HIV testing and counselling, prevention, care, support and treatment, for people living with TB. WHO will also issue new guidelines on providing comprehensive TB and HIV prevention, treatment and care services for drug users in late 2008.

WHO continues to advocate for and to support expanded global HIV/TB control and treatment efforts, as well as expanded efforts at the country level to address issues such as partner testing, family planning, discordant couple counselling and HIV and TB case-finding among family members.

Q. What resources are needed for improved TB control?

A. An estimated US$ 4.8 billion is needed for overall TB control in low and middle-income countries in 2008, with US$ 1 billion required for MDR-TB and XDR-TB alone.