Scaling-up Towards Universal Access to HIV Prevention, Treatment and Care

Report of the WHO-UNAIDS Joint Regional Technical Briefing on Universal Access

8 December 2005

Kathmandu, Nepal

World Health Organization
REGIONAL OFFICE FOR South-East Asia

Joint United Nations Programme on HIV/AIDS
UNAIDS
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SEA/AIDS/160

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Printed in India

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Abbreviations

AIDS	acquired immunodeficiency syndrome
ART	antiretroviral treatment
ASEAN	Association of Southeast Asian Nations
CIDA	Canadian International Development Agency
GFATM	Global Fund to fight AIDS, Tuberculosis and Malaria
HIV	human immuodeficiency virus
IDU	injecting drug user
MDGs	Millennium Development Goals
MSM	men having sex with men
RSTAP	UNAIDS Regional Support Team for Asia and Pacific
SEARO	Regional Office for South-East Asia
SAARC	South Asia Association for Regional Cooperation
STI	Sexually transmitted infections
UNAIDS	United Nations Programme on HIV/AIDS (UNAIDS)
UNICEF	United Nations Children's Fund
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session
WHO	World Health Organization

Introduction

Global HIV/AIDS burden

The HIV/AIDS pandemic is considered to be the most serious public health threat to global stability and progress. An estimated 60 million people have been infected with HIV and more than 25 million have died since the start of the epidemic. By the end of 2005, an estimated 40.3 million (36.7–45.3 million) are living with the virus. The rate of new infections continues to increase each year. Close to 5 million people were newly infected with the virus in 2005.

AIDS responses have grown and improved considerably over the past decade but they still do not match the scale or the pace of a steadily worsening epidemic. Between 2003 and 2005, access to antiretroviral treatment has improved markedly. However, treatment coverage still remains low in many countries in Africa and Asia. Indications are that some of the treatment gaps will narrow further in the immediate years ahead, but not at the pace required to effectively contain the epidemic. It has long been recognized that gaining the upper hand against AIDS epidemics around the world will require rapid and sustained expansion in HIV prevention. Currently, less than one person in five at risk of HIV has access to basic HIV prevention services. This gap in access to HIV prevention services and the fact that interventions have not been taken to the scale needed to make a significant impact on the global incidence of HIV, have contributed to the rising numbers of people living with HIV. This is particularly true for women, now representing just under half the people living with HIV, and youth, who comprise over half of all new infections.

HIV/AIDS burden in South-East Asia

The South-East Asia Region, home to 6.7 million people living with HIV, has the second highest burden of HIV/AIDS in the world after sub-Saharan Africa. This Region, committed to the "3 by 5" initiative, documented remarkable achievements in scaling up antiretroviral treatment (ART) in the recent past and witnessed a four-fold increase in the number of people on ART since December 2003. This achievement, however, is not enough as less than 20% of persons in need of treatment are currently receiving ART. A major obstacle to treatment is the lack of access to HIV testing and counselling services. Despite dramatic

developments in political commitment, funding and treatment provision, very little progress has been made in prevention and eliminating stigma and discrimination.

Most countries in the region lack large-scale prevention programmes designed for the most vulnerable populations. For example, HIV-prevention programmes reached only 19% of sex workers in south and south-east Asia. No more than 2% of men who have sex with men (MSM) have access to such programmes. Even though injecting drug use is an important driving force behind the spread of HIV in the region, proven prevention measures are available only to 5.4% of injecting drug users (IDUs). There is an urgent need to increase coverage of targeted interventions such as 100% condom use for sex workers, needle–syringe exchange programmes and substitution therapy for IDUs.

HIV/AIDS response in South-East Asia

The Millennium Development Goals (MDGs), target 6, aims at halting and beginning to reverse the spread of HIV/AIDS by 2015. However, the Millennium Development Goals Report of 2004 showed that though some progress has been made to meet the global targets of controlling HIV/AIDS, an alarming increase in the numbers of HIV-infected persons in the Region has outpaced the success, putting the countries in this Region behind schedule. Unless the gap in prevention, treatment and care is reduced rapidly, the epidemic will cause an irrevocable social and economic havoc in the Region.

Scaling-up of the HIV/AIDS strategy in the Region involves developing a comprehensive response to HIV/AIDS (that includes prevention, treatment and care) as well as addressing the need to expand coverage geographically, to reach more people. It also focuses on increasing coverage to different population types, improving the quality and scope of services, and ensuring that the involved systems are accountable. The ultimate goal is to guarantee the delivery of a comprehensive range of interventions and programmes to reduce the transmission of HIV/AIDS and lessen its impact on individuals and societies.

Objectives of the meeting

The Joint United Nations Programme on HIV/AIDS (UNAIDS) and World Health Organization, Regional Office for South-East Asia (WHO SEARO) hosted a joint meeting on 8 December 2005 in Kathmandu, Nepal to discuss the process of moving towards universal access to HIV/AIDS prevention, treatment and care by 2010. The meeting was attended by 50 participants including, country representatives from Bangladesh, Bhutan, DPR Korea, Indonesia, Maldives, Myanmar, Nepal, Sri Lanka and Thailand; donors—Canadian International Development Agency (CIDA); representatives from the civil society; South Asia Association for Regional Cooperation (SAARC); WHO and UNAIDS staff from headquarters, regional and country offices; representatives of United Nations Population Fund (UNFPA), United Nations Development Programme (UNDP) and United Nations Children's Fund (UNICEF). The programme details and the list of participants are provided in Annex 1 and 2, respectively.

The specific objectives of the meeting were:

- To initiate a country-led consultative process, for developing a comprehensive package of action for achieving universal access to prevention, treatment and care by 2010;

- To involve key stakeholders in the South-East Asia Region (eleven countries) and Pakistan in developing the components of the comprehensive package; and

- To help maintain the momentum in countries and by partners for fulfilling the MDG and United Nations General Assembly Special Session (UNGASS) goals and targets.

Inaugural session

The meeting opened with a welcome address by Mr JVR Prasada Rao, Director, UNAIDS Regional Support Team for Asia and Pacific. He thanked WHO SEARO in co-organizing the joint briefing. He emphasized that universal access is not a new United Nations initiative but took shape as a collective declaration of the UN General Assembly. Universal access is meant to be a country-led initiative, not a top-down approach. Countries need to define where they are today and what would be achieved by 2010 as a midway target to the MDGs by 2015. He indicated that the main expectations from this meeting were the discussion of opportunities, impediments and the next steps in the process of attaining universal access.

Dr JP Narain, Director Communicable Diseases, WHO SEARO, extended a warm welcome to all the participants and said that this meeting was an example of collaborative activities between WHO and UNAIDS. He highlighted that universal access is an important initiative to scale up coverage and quality of HIV/AIDS interventions, particularly for the poor and marginalized populations. He urged that countries set up short- and medium-term milestones to be achieved by 2010 with the guiding principles and lessons learned from the "3 by 5" initiative. He said that universal access is a challenge and also an extraordinary opportunity to develop health system capacity. Universal access would need the full involvement of all stakeholders, in particular, active participation of the national AIDS programme managers. Dr Narain added that WHO and UNAIDS are fully committed to assist and support the Member States in the process of achieving the universal access goals.

The inaugural session ended with the appointment of Dr Gampo Dorji, National AIDS Programme Manager, Bhutan as the chair in the morning session and Dr Sujatha Samarakoon, Venerologist, Srilanka and Dr Farah Usmani, from UNFPA Country Support Team for South Asia as the co-chairs for the meeting.

Conceptual framework for universal access

Dr Olavi Elo from UNAIDS, Geneva highlighted the major gaps in HIV/AIDS services across the world, particularly prevention services, and emphasized that universal access was an evolving partnership between donors and developing countries to help them scale up their national HIV response. At the July 2005 Gleneagles Summit, the G8 countries agreed to increase official development assistance and called on UNAIDS, WHO and other international bodies to develop and implement a package for HIV prevention, treatment and care with the aim of reaching as close as possible to universal access to treatment for all those who need it by 2010. In September 2005, the General Assembly of the United Nations committed to the scaling up of comprehensive HIV/AIDS responses, at the World Summit.

Building on the 2001 UNGASS Declaration of Commitment, scaling-up towards universal access by 2010 will serve as a midpoint to achieving the MDG—to halt and begin to reverse the spread of HIV/AIDS by 2015. The universal access goal puts countries firmly in command of setting their prevention, treatment and care targets for 2010, by addressing critical obstacles to universal access, and reinforcing global commitment to scale-up national AIDS responses and accomplish MDG for HIV/AIDS.

The process for universal access should include:

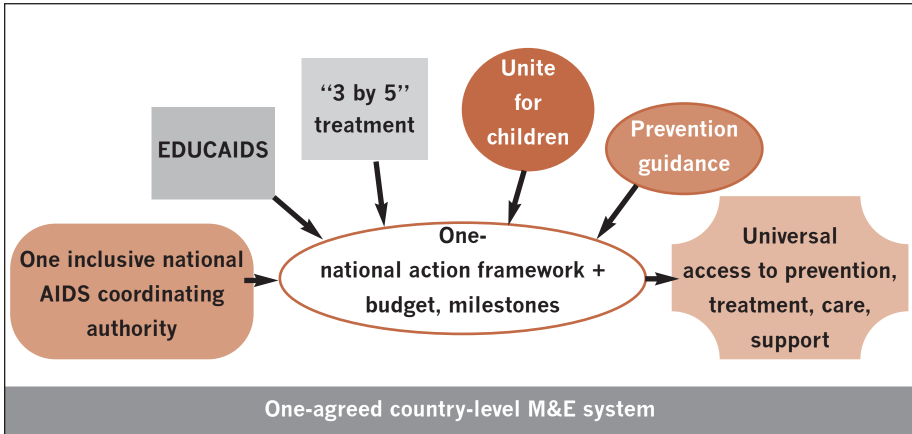
- *Country consultations* to produce a "roadmap" reflecting key milestones and major interventions to work towards universal access by 2010; identify critical obstacles to universal access and report to the regional consultations.

- *Regional consultations* to discuss country products and regional support to solve obstacles and report to the Global Steering Committee.

- *Global Steering Committee recommendations* on how to address outstanding obstacles and providing guidance to the process and to compile and present the global report for consideration to the 2006 UN General Assembly.

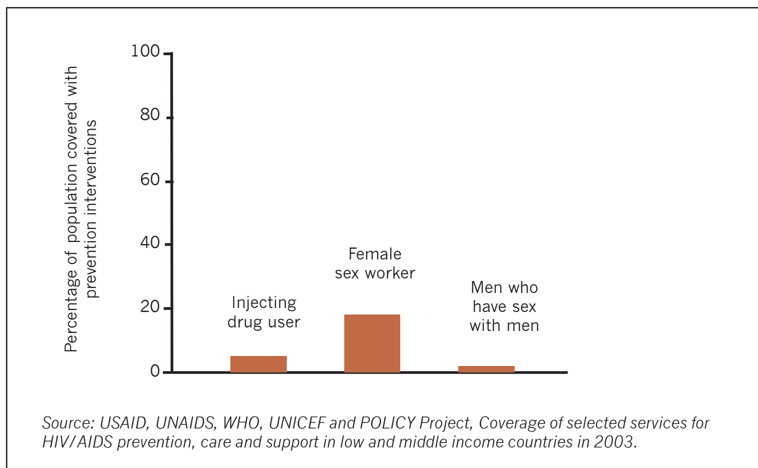
Figure 1 gives a conceptual framework of the universal access process encompassing the three-ones principles and highlights the linkages with global initiatives, e.g.: "3 by 5", Unite for Children, etc.

Figure 1. Framework for universal access integrating the ''Three Ones'' principle



Dr Ying-Ru Lo, Regional Advisor for HIV/AIDS, WHO SEARO presented the progress made in prevention and treatment services in countries in the Region and highlighted the huge unmet need for prevention services, particularly for the vulnerable populations. (Figure 2).

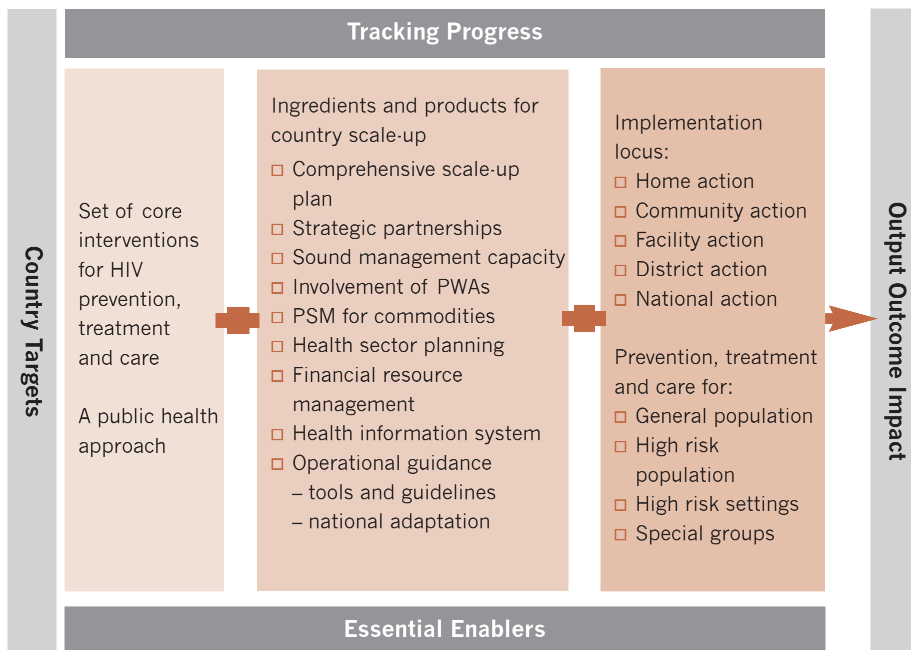
Figure 2. Proportion of vulnerable population covered with prevention services, south-east Asia, 2003



Source: USAID, UNAIDS, WHO, UNICEF and POLICY Project, Coverage of selected services for HIV/AIDS prevention, care and support in low and middle income countries in 2003.

Dr Clem Chan from WHO, Geneva proposed a framework to help countries define what universal access would mean in their context (Figure 3). He emphasized that the elements of the essential package for universal access to prevention, treatment and care should include the following: promotion of safer sex, condom use, and sexual and reproductive health; comprehensive package of interventions for sex workers, IDU, MSM and young people; strengthened sexually-transmitted infections control; HIV testing and counselling; positive prevention (prevention for HIV positive persons); and prevention of mother-to-child transmission.

Figure 3. Framework for universal access to HIV prevention, treatment and care within the health sector



Opinion of SAARC and civil society

Mr Mohamed Naseer, Director of Social Affairs Division of SAARC, presented the new SAARC HIV/AIDS strategy and mentioned that this strategy would provide the basis for regional HIV/AIDS cooperation. The SAARC secretariat will be supported by the UNAIDS Regional Support Team for Asia and Pacific (RSTAP) to operationalize this strategy and to provide management capacity for the programme. As a regional political organization, SAARC could play an important role in the country-led process in the future, and will be involved in the regional consultations and in country-level follow-up activities.

Representatives of the civil society highlighted the need to expand collaborations with the other sectors, such as education. The need for a continuum of care and support, including psychosocial support and employment of people living with HIV, was also highlighted. Civil society representatives called for the operationalization of national policies at the local level. The need for advocacy at the district and provincial levels was also emphasized. The civil society could play a bigger role in the response to the HIV epidemic if they were better informed and truly empowered. The session emphasized that:

- Civil society is a key partner in the delivery of HIV/AIDS services.
- Universal access is not about numbers but access to a full range of services as well as expansion in geographical coverage.
- The complete involvement of people living with HIV and highly vulnerable groups in a meaningful way is fundamental in universal access efforts.
- Discrimination and stigma still are major barriers.
- Universal access at the country-level needs to focus on human rights.

Opportunities, obstacles and suggestions in achieving universal access at the country level

During the discussions, the following opportunities, obstacles and follow-up actions were listed by the representatives of the Member countries (Refer Annex 3 for details):

Key opportunities

- High political commitment at the national level.
- Adequate finances (with the exception of Myanmar).
- Increased momentum generated by the "3 by 5" strategy.
- Generic production of drugs.
- Availability of funding from Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM).
- Availability of national guidelines on technical issues.
- Support from communities and the civil society.

Key challenges and obstacles

- Lack of an enabling environment in most of the countries (including culture and social norms in supporting and practicing harm reduction approaches and condom promotion policies) of the region.
- Lack of adequate baseline data creating difficulties in setting realistic targets (e.g. size of the high-risk population is unknown).

- Lack of harmonization between government departments and donors, and within donors themselves.
- Large populations and wide geographical terrain.
- Human trafficking and migration which are common challenges in the Region cannot be covered by national AIDS programmes alone.
- Suboptimal co-ordination with the private sector and donors, including insufficient networking with private hospitals.
- Limited human resource particularly at the local level.
- HIV-associated stigma and discrimination preventing greater involvement of people with HIV and vulnerable populations.
- Difficulties in procurement of drugs, equipment and services.

Follow-up actions suggested by the participants

- Formal communications on universal access needed as soon as possible with the governments.
- Simple and focused guidelines needed for universal access.
- Involvement of all stakeholders required, including multiple sectors, civil society, private sector, UNAIDS co-sponsors.
- Consideration and respect for the ongoing country-level processes in the country, such as national review, strategic planning.
- Involvement and commitment of political leaders, National AIDS Committee for the in-country universal access process.
- Challenging but realistic targets needed.
- Complete involvement of people with HIV and highly vulnerable groups, in a meaningful manner, needed and is fundamental to the universal access process.
- A focus on human rights needed in the universal access process.
- Improved coordination among UN agencies needed at the country level.

Summary and follow-up

The main components of universal access have been developed in the past years but these interventions now need to be scaled-up. Universal access should be a country driven process with countries setting their own realistic but challenging targets.

Member countries are committed to initiate or continue the national consultations and preparations for the regional consultation to move towards the process of universal access, with the understanding that these would not be a duplication of the existing work, and that the "Three Ones" principles and Global task team recommendations would provide the basis for scaling up towards universal access.

It was agreed that the next steps in the process of universal access would include:

- *Country level consultations* that would review national strategic plans and setting of realistic but challenging targets for output, outcome, and impact indicators. The consultations should engage a wide variety of stakeholders and would be facilitated by the UN partners.
- *Preparation of country reports*. Every country has to submit a 20–25 page country report by 31 January 2006. This should include a situational analysis (epidemiological situation and status of the national response), identification of obstacles and clear steps to overcome it (enabling environment, infrastructural, resource and capacity, etc.).
- *Regional consultation*. The consultations for the Asia and Pacific Region will be hosted by the Royal Thai Government. The purpose of the consultation would be to inform stakeholders and check progress in the universal access process. The consultation for the Asia and Pacific Region is tentatively scheduled to be held from 14 to 16 February 2006 in Pattaya, Cholburi Province, Thailand. The regional report should be finalized by 28 February 2006.
- *Preparation of the global report*. The various regional reports will be compiled to prepare the global report to be considered by the UN General Assembly Special Session on HIV/AIDS in 2006.

Annex 1: Programme

08:30 – 09:30 Opening

Welcome Address

- Mr Prasada Rao, Director, UNAIDS Regional Support Team for Asia and Pacific, and
- Dr Jai P Narain, Director, Communicable Diseases, WHO SEARO

Objectives of the meeting, introduction of participants, administration UNAIDS RSTAP and WHO SEARO

Group photo

09:30 – 10:00 Tea/Coffee Break

10:00 – 12:00

Briefing on country-led process for scaling up towards universal access to prevention, treatment, care and support by 2010

Chair: Dr Jai P Narain

- Global initiative on "Scaling Up Towards Universal Access": Country-led process and sub-regional groupings

  Dr Olavi Elo, UNAIDS
- Universal access to HIV/AIDS prevention, care, treatment and support: Essential package in the health sector

  WHO headquarters and SEARO
- Plenary discussion

12:00 – 13:00 Lunch

13:00 – 14:30

Panel discussion on the obstacles and opportunities to scaling up towards universal access faced by countries in the region

Chair: Dr Prasada Rao

- National Programme Managers from WHO SEARO countries and Pakistan, and representatives from SAARC and ASEAN (5 min each)
- Discussion

14:30 – 15:00 Tea-Coffee Break

15:00 – 17:00

Perspective of representatives from Civil Society, UN agencies and donor community

Chair: A National Programme Manager (TBI)

- Reflections from Civil Society, UN Agencies, Donor Community (5 min each speaker)
- *Discussion*

Road Map for future action

- Steps for country-led process and the compilation of country-level work into a sub-regional contribution to a global framework to be considered by the 2006 UN General Assembly Special Session on HIV/AIDS.

Conclusions

Closing

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Annex 3: Country-specific opportunities and obstacles to scaling up prevention, treatment and care services

Bangladesh

Opportunities

- National AIDS Committee formed since 1985 showing a strong commitment with early development of a national policy and strategic plan.
- A revised national strategic plan developed and a detailed operational work plan being developed.
- Blood safety act issued; has had a substantial impact in strengthening blood safety.
- Good support from the donor community, including GFATM.
- Data on size of target populations available.
- Good collaborating environment among partners.

Obstacles

- Limited capacity of the Ministry of Health.
- HIV-associated stigma and discrimination prevalent.
- Limited staff and high turnover of AIDS programme managers.
- Law enforcement environment criminalizes sex work thus limiting HIV prevention programmes.
- Lack of co-ordination among donors.

Bhutan

Opportunities

- High political and administrative commitment for HIV prevention and care.
- Successful engagement of other sectors; multisectoral task forces operational at all governmental levels.
- Good support from regional agencies, such as SEARO, SAARC.

Obstacles

- Difficulties in targeting interventions to high-risk groups as they are not easily identifiable.
- Lack of availability of strategic information and baseline data on populations with high-risk behaviour.
- Liberal cultural traditions and norms making it difficult to implement behaviour change interventions.

- Cross-border migration and illicit substance trade across borders, which is beyond the control of national authorities.
- Insufficient budgetary allocation for HIV, due to competing programme priorities with other communicable and non-communicable diseases.

DPR Korea

Opportunities

- No HIV infection/AIDS cases reported to date.

Obstacles

- Lack of HIV test kits.
- Insufficient IEC materials.
- Difficulties in conducting training on HIV/AIDS.

Indonesia

Opportunities

- Conducive policy environment.
- High political commitment at central level.
- Adequate funds available, currently.

Obstacles

- Limited capacity of the health system.
- Weak AIDS committees at the provincial level.
- Difficulties in coordinating donor support to avoid duplication.
- Lack of trained human resources in monitoring and evaluation.
- Non-acceptance of the national policies at the local levels, particularly on the topic of harm reduction.
- Insufficient focus on youth although it is an important priority group.
- Prevailing HIV-associated stigma and discrimination.
- High cost of antiretroviral drugs.

Myanmar

Opportunities

- High political commitment.
- The national HIV/AIDS strategic planning for 2006–2010 is underway.
- Regular HIV Sentinel Surveillance started since 1992 has been strengthened further with the integration of behavioural surveillance and sexually transmitted infections (STI) surveillance.
- Availability of a technically sound strategic plan, which is currently being revised with involvement of stakeholders.
- Efforts to build capacity of the National AIDS Progamme and human resources is currently underway.

Obstacles

- Chronic shortage of funds.
- Sudden, unilateral withdrawal of the GFATM funds that were mobilized for scaling up ART.
- Difficulties in procurement and supply of medicines and diagnostics.
- Limited infrastructure of the public health sector.
- Limited human resources and suboptimal mobilization of private sector and NGOs.
- HIV-associated stigma and discrimination continues to be a barrier for access to services to those who need them.
- Limited collaboration with other sectors, such as the police, whose support is required to provide services to vulnerable and marginalized populations, such as sex workers and injecting drug users.
- Inadequate harmonization among donor and technical partners including that with UN agencies.

Nepal

Opportunities

- Existence of a national strategic plan.
- Involvement of people with HIV in national planning.

Obstacles

- Political instability.
- Infrequent meetings of the National AIDS Council.
- Frequent turnover of the national AIDS programme managers.
- Health delivery system not yet integrated at a decentralized health system.
- Lack of capacity of the government, particularly at the peripheral level.

Pakistan

Opportunities

- High political commitment.
- Decriminalization of drug use facilitated implementation of interventions and collaboration with communities.
- Favourable change in the pharmaceutical policy allowing the import of less expensive generic drugs from India.
- The process to develop a national framework/national policy on HIV/AIDS is underway with support of the government.
- High-risk populations have been mapped and quantified.
- Home-grown models generating from the community for working with IDUs will ensure sustainability.
- Education including and HIV prevention strategy for the youth.
- Engagement of the religious leaders and the media.

- The ART programme, which started with GFATM support, is now being supplemented by government funds.

Obstacles

- Weak monitoring and evaluation and strategic information for policy makers
- Inadequate programme management capacity.
- Insufficient human resources.
- Non-utilization of available moneys.
- Lack of harmonization and co-ordination among donors at the country level.
- Insufficient attention to youth as a vulnerable group.
- Difficulties in ensuring quality of services in the process of scaling up.

Sri Lanka

Opportunities

- Prevalence of HIV is still low.
- High political commitment at the moment.
- Good financial commitment so far.

Obstacles

- The three ones is not yet in place.
- Weak monitoring and evaluation system.
- Lack of clear terms of reference for the National AIDS committee.
- Access to health care services is still limited, so scaling up ART may take time.
- Co-ordination and consultation among partners remains to be improved.
- Providing universal access in conflict areas will be particularly difficult.
- Lack of availability of baseline information of target groups makes it difficult to plan and set targets.

Thailand

Challenges

- The changing environment of the sex industry (from direct to indirect sex work) has made it more difficult to access this group for prevention, treatment and care services.
- Closure of STI clinics and moving STI services from hospitals to the already overburdened primary health centres has weakened the quality of STI services.
- Difficulties in convincing sex workers to use integrated health services.
- Difficulties in providing community or home-based care, comprehensive prevention treatment and care and TB/HIV services.
- Access to marginalized populations, such a migrant workers, represents a real challenge as many of the migrants do not have a legal residential status.
- Increasing access of services to other marginalized and minority groups, such as MSM or IDUs.

World Health Organization

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