

INVESTING IN A COMPREHENSIVE HEALTH SECTOR RESPONSE TO HIV/AIDS

Scaling up Treatment and Accelerating Prevention



World Health Organization

WHO HIV/AIDS PLAN

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Acronyms and abbreviations

AIDS	acquired immunodeficiency syndrome
AMDS	AIDS Medicines and Diagnostics Service
HIV	human immunodeficiency virus
MTCT-Plus	programmes intended to provide lifelong care and treatment to women living with HIV/AIDS identified through programmes for the prevention of mother-to-child transmission and to their families
TB	tuberculosis
“3 by 5”	the target of having 3 million people in developing countries on antiretroviral therapy by the end of 2005
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNICEF	United Nations Children’s Fund
WHO	World Health Organization

Foreword

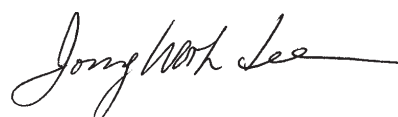
The HIV/AIDS epidemic is the single most important challenge facing the global public health community. A comprehensive response to HIV/AIDS is needed to expand evidence-based prevention interventions and to ensure that the people in need receive effective care, treatment and support.

Great progress has been made over the past few years in making antiretroviral therapy an affordable and realistic option for even the most resource-constrained countries. Ways to ensure that treatment and care effectively support prevention efforts are becoming increasingly clear. The challenge now is to translate these opportunities into action.

I have always believed that time-limited targets promote accountability, mobilize action and focus efforts in the face of major challenges. HIV/AIDS is no exception. Although the “3 by 5” target is ambitious, a lack of ambition now will condemn many people to a preventable death and make the task of controlling HIV/AIDS even more difficult in the years ahead.

In places where no comprehensive programme has previously been in place, mounting a rapid response to HIV/AIDS that includes antiretroviral therapy and more robust prevention efforts will inevitably involve complexity and uncertainty. Many partners need to be involved. They need to be clear about what they can contribute, what it will cost and what they aim to achieve. I am therefore very pleased to present the WHO HIV/AIDS Plan for 2004–2005, which outlines how WHO proposes to help countries in mounting a comprehensive response to HIV/AIDS during 2004 and 2005 and what this will cost.

Several donors have already made substantial contributions to WHO to enable us to support treatment scale-up and move towards realizing the “3 by 5” target. The progress and achievements made since WHO and UNAIDS launched the “3 by 5” Initiative in December 2003 are outlined in the enclosed “3 by 5” *Progress Report*. However, the full WHO HIV/AIDS Plan requires additional funding of US\$ 62 million for full implementation. These resources are needed urgently, and WHO encourages additional partners to commit to and support this effort.



LEE Jong-wook
Director-General
World Health Organization

Executive summary

During 2003, an estimated 4.1 million people 15–49 years old became infected with HIV, with an additional 630 000 children becoming infected. HIV/AIDS killed about 3 million people in the same year. This occurred despite the existence of proven interventions that can prevent transmission and of life-saving antiretroviral therapy. However, of the 5.5 million people in developing and transitional countries (other than Canada, the United States of America, countries in western Europe, Australia, New Zealand and Japan) estimated to need antiretroviral therapy, only 440 000 had access to it by 30 June 2004, representing an increase of only 40 000 people in the first six months of 2004.

WHO's HIV/AIDS programme focuses on assisting governments and other stakeholders in implementing a coordinated and comprehensive health-sector response to HIV/AIDS. Consistent with the Declaration of Commitment of the United Nations General Assembly Special Session on HIV/AIDS and the Global Health-Sector Strategy for HIV/AIDS 2003–2007, this response incorporates a spectrum of HIV/AIDS and related services, including prevention, treatment, care and support. It also must include appropriate health systems standards, skills mix, supportive policies and partnerships that enable effective multisectoral approaches.

As in the past, prevention efforts remain a high priority for WHO, especially among vulnerable populations and in clinical settings. However, until now, treatment is the element that a majority of developing countries have neglected most in their comprehensive national response to HIV/AIDS. The lack of treatment has helped to perpetuate stigma and discrimination and greatly reduced the impact of prevention and care efforts, including uptake of HIV testing and counselling. A significant new component of WHO's HIV/AIDS programme in 2004–2005 therefore includes activities to support Member States in scaling up treatment and in realizing the global target of having 3 million people in developing countries receiving antiretroviral therapy by the end of 2005.

With significant new resources now available to scale up national HIV/AIDS programmes, countries face particular challenges in ensuring that they and their partners effectively manage, coordinate and monitor their efforts at the national level, contribute to overall health systems development and address pressing social challenges such as promoting greater involvement of people living with HIV/AIDS and affected communities, elevating the social status of women and girls and promoting equitable access to services. WHO's HIV/AIDS programme is designed to contribute to attaining these broad social goals.

The WHO HIV/AIDS Plan for January 2004–December 2005 presents the strategic and resource framework for WHO's HIV/AIDS programme. It describes the work of WHO in providing support to countries as they develop and implement their national scale-up plans. It includes an introductory epidemiological situation analysis and the most recent estimates of antiretroviral therapy coverage by region. The WHO HIV/AIDS Plan is not a detailed work schedule; it provides a framework for developing detailed work plans, with specific time-bound activities and responsibilities necessary to bring the WHO HIV/AIDS Plan to fruition at all levels of WHO. In addition, detailed joint plans are being developed with UNAIDS Cosponsors to coordinate, align and integrate work at country level.

The WHO HIV/AIDS Plan for January 2004–December 2005 is designed to draw on the comparative advantage of the WHO as the specialized agency on health within the United Nations system. It seeks to strengthen WHO's role in supporting the coordination of national responses in the health sector, convening stakeholders and stimulating new partnerships. These partnerships will not only include those with and between the United Nations organizations and the governments of Member States but will also involve technical agencies, donors, civil society groups, organizations of people living with HIV/AIDS and the private sector.

Consistent with the WHO programme budget for 2004–2005, the HIV/AIDS programme encompasses activities in five functional areas:

- strategic information
- advocacy and policy
- technical and normative guidance
- country capacity-building
- operations research and knowledge management.

These functional areas focus on scaling up treatment, care and support and accelerating HIV/AIDS prevention through action in the health sector.

In determining its programme objectives in 2004–2005 for HIV/AIDS as well as in other areas of work, WHO will focus a greater proportion of its human and financial resources at the regional and country level. To specifically improve the support provided to Member States in scaling up HIV treatment and accelerating prevention, “3 by 5” teams will be in place in focus countries by the third quarter of 2004. More intensive and comprehensive country profiling systems now being implemented will enable technical support needs to be assessed more effectively and responses tailored appropriately to meet country needs. The proportion of the total HIV/AIDS budget dedicated to the regional and country levels is increasing from 66% in 2002–2003 to 87% in 2004–2005, with the African Region of WHO receiving 55% of total funds.

WHO will also be strategic about where and how it provides technical assistance. Although it will continue to respond to requests from all Member States, WHO will concentrate its resources in countries where the burden of disease is most acute and where positive impact is anticipated to be greatest. WHO will focus on technical areas in which it has a comparative advantage.

A new Strategic and Technical Advisory Committee will be established to provide guidance to the WHO HIV/AIDS programme, and regular reports covering “3 by 5” milestones and expected results will be published.

The WHO HIV/AIDS Plan for January 2004–December 2005 sets out anticipated resource requirements of US\$ 218.1 million for WHO’s HIV/AIDS programme across all levels of the Organization during 2004–2005, of which US\$ 62 million remained unfunded as of 1 July 2004. Additional financial support to close this funding gap is needed if the full programme of work described in the WHO HIV/AIDS Plan is to be implemented.

Key documents related to the WHO HIV/AIDS Plan

Document	Purpose
<i>Investing in a comprehensive health-sector response to HIV/AIDS. Scaling up treatment and accelerating prevention. WHO HIV/AIDS Plan for January 2004–December 2005</i> , July 2004	Describes the strategic and resource framework specifically for WHO in the HIV/AIDS area of work during 2004–2005 and lays out WHO’s role in scaling up treatment and care and accelerating prevention. Describes the roles of each level of the WHO structure and the financial and human resources allocated to each.
Country profiles, first edition (26 countries), July 2004	Practical tool for use at the country level to guide countries in scaling up their response to HIV/AIDS, monitor progress and clarify roles among partners. Will be updated frequently as the situation develops in each country.
<i>“3 by 5” Progress Report: December 2003–June 2004</i> , July 2004	Reports on global progress by all countries towards achieving the target of having 3 million people in developing countries receiving antiretroviral therapy by the end of 2005. It also reports the status of the June 2004 key milestones for 15 global monitoring indicators outlined in the “3 by 5” strategy document <i>Treating 3 million by 2005 – making it happen</i> . To be issued every six months.
WHO HIV/AIDS work plan, September 2004	Describes the work WHO will carry out during 2004–2005 to deliver the agreed programme budget outcomes. Details will include activities, responsibility, cost and timing at the country, regional and headquarters levels. Work plans are typically not formally published but can be made available on request.
Joint United Nations HIV/AIDS country-level response on “3 by 5”, October 2004	Describes for each country the roles and responsibilities of all UNAIDS Cosponsors and other United Nations organizations at the country level in supporting countries’ response to “3 by 5”. It will detail specific tasks, responsibilities, budgets and timing.

1. Background

1.1 Purpose of this document

This document discusses the context for the work being undertaken in WHO's HIV/AIDS programme. It analyses the epidemiological situation and includes the most recent estimates of antiretroviral coverage, the global strategic framework and current challenges to translating this into results at the country level (Section 1 – Background).

Section 2 describes the comparative advantages offered by WHO, the functional areas of activity within the HIV/AIDS area of work for 2004–2005 and the specific focus of the programme on scaling up antiretroviral therapy and accelerating HIV prevention.

Section 3 describes how WHO is structured and how resources and capacity are being reoriented to support country-level action.

Section 4 illustrates how WHO works within the United Nations system and with other partners.

Section 5 outlines the resources required in 2004–2005 for WHO to accomplish its stated contribution to HIV/AIDS.

Section 6 describes the mechanisms for technical and managerial oversight of the HIV/AIDS programme.

The WHO HIV/AIDS Plan is not a detailed work plan. Rather, it provides an overall framework to guide the departments responsible for HIV/AIDS in preparing such work plans at the country, regional and headquarters levels of WHO. These work plans are now being developed and will define the specific tasks and activities required to bring the WHO HIV/AIDS Plan to fruition, together with timelines and resource requirements. Joint planning sessions between headquarters, regional and country offices integrate the work of the three levels to ensure that all priority needs are addressed and that gaps in resources are identified.

1.2 Situation analysis

1.2.1 Global overview

UNAIDS and WHO have estimated that the number of people living with HIV/AIDS at the end of 2003 was 37.8 million (34–42 million). This includes 2.1 million (1.9–2.6 million) children younger than 15 years of age. During 2003, an estimated 4.1 million (3.6–5.6 million) people 15–49 years old were newly infected, with an additional 630 000 (570 000–740 000) incident infections in children. The estimated number of people who died during 2003 from illness related to HIV/AIDS is 2.9 million (2.6–3.3 million). Most of these deaths (2.2 million) occurred in sub-Saharan Africa, where coverage of antiretroviral therapy remains low.

Sub-Saharan Africa, which has an estimated 25.0 million (23.1–27.9 million) people living with HIV/AIDS, is the region with the highest burden, constituting almost 70% of people living with HIV/AIDS worldwide. South, South-East and East Asia follow with 7.4 million (4.6–11.1 million), with 2.0 million (1.4–2.8 million) occurring in Latin America and the Caribbean, 1.9 million (1.3–2.6 million) in Europe and central Asia, 1.0 million (0.5–1.6 million) in North America and 0.5 million (0.2–1.4 million) in northern Africa and the Middle East. Of the 37.8 million people living with HIV/AIDS worldwide, 2.1 million are children under the age of 15. Again, the great majority, 1.9 million (1.7–2.2 million) are living in sub-Saharan Africa and were infected as a result of mother-to-child transmission.

Given the high prevalence of people already infected and despite the large numbers of people dying every year, the number of people living with HIV/AIDS continues to increase by about 1.5 million per year. In the mid-1990s, when the growth in the global HIV epidemic peaked, that growth was almost entirely driven by the epidemics in sub-Saharan Africa and South and South-East Asia. The picture is now much more diverse. In 2002–2003 the western Pacific and eastern Europe contributed substantially to global growth.

In 2003, the estimated worldwide number of people needing antiretroviral therapy in developing and transitional countries was nearly 6 million. This figure was based on mortality estimates. Such estimates have to be interpreted with some caution, as they can vary in countries that use different criteria for starting antiretroviral therapy. In addition, the uncertainty ranges for the number of people living with HIV/AIDS (34–42 million) and for the number of people who need antiretroviral therapy (4–8 million) are wide. The most important uncertainty is around the size and trend of the epidemic in some countries. The global HIV treatment needs over time will increase as more people develop AIDS each year and the people who are accessing antiretroviral therapy and surviving will need to keep taking medication.

Tuberculosis (TB) remains a major killer of people with HIV/AIDS. WHO figures show that TB accounts for up to 13% of AIDS deaths worldwide. In Africa, HIV is the single most important factor determining the increased incidence of TB in the past 10 years. Antiretroviral therapy has been shown to reduce susceptibility to TB disease by 80–90% in both industrialized and developing countries.

1.2.2 Overview of the “3 by 5” focus countries

Annex 1 presents a list of 49 countries identified by WHO for initial, intensified technical support and dedicated resources to scale up antiretroviral therapy and accelerate HIV/AIDS prevention. The list comprises a combination of global and regional priorities. On a global basis, WHO identified the 34 countries with the highest unmet treatment need for focused attention. These 34 countries account for 85% of the unmet treatment need globally. In addition, several WHO regions identified groupings of countries (such as the central Asian republics) having specific regional strategic significance (such as a rapidly spreading epidemic) that were also felt to require focused and urgent attention.

WHO will continue to support Member States not appearing on this list of countries. Section 3.2 outlines the HIV/AIDS support provided to all Member States.

In total, these 49 countries account for 73% of the global people living with HIV/AIDS, 78% of the mortality from HIV/AIDS in developing and transitional countries and 86% of the people needing treatment in developing and transitional countries; nevertheless, their estimated coverage for antiretroviral therapy is only 4.0%. Six countries comprise a full 50% of the global treatment needs: South Africa, India, Nigeria, Zimbabwe, the United Republic of Tanzania and Kenya.

1.2.3 Estimates of global and regional coverage

In 2001, a group of partners including the United States Agency for International Development, UNAIDS and WHO carried out a survey of HIV/AIDS treatment coverage in health services. The survey estimated that about 300 000 people in developing countries were receiving antiretroviral therapy at that time, representing 2% of the total estimated need. In December 2003 when the “3 by 5” target was established, an estimate was made that about 400 000 people were receiving antiretroviral therapy.

Using a variety of direct country-level information sources, WHO now estimates that 440 000 people had started receiving antiretroviral therapy by June 2004, representing 8% of the total estimated needs (Table 1 presents the overall results). Although this increase is substantial compared with the 2001 estimates, the gap between needs and coverage remains large. Antiretroviral therapy coverage is lowest in the African Region of WHO, where the burden is highest. Only an estimated 150 000 people were receiving treatment in the African Region by June 2004; the estimated coverage of 4% nearly doubles the coverage estimated in December 2003.

These coverage estimates are somewhat uncertain because many countries have not yet fully implemented monitoring systems for antiretroviral therapy and may not have included everyone in care in the private sector. Treatment in the private sector has been available for some time, although high prices for care, laboratory support, and medication may have limited access through these services.

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Table 1. Estimated antiretroviral therapy coverage and overall antiretroviral therapy needs in developing and transitional countries^a according to regions of WHO

WHO region	Estimated number of people on antiretroviral therapy, June 2004	Estimated antiretroviral therapy need, 2004–2005 ^b	Antiretroviral therapy coverage
African Region	150 000	3 840 000	4%
Region of the Americas	220 000	410 000	54%
European Region	11 000	120 000	9%
Eastern Mediterranean Region	4 000	100 000	4%
South-East Asia Region	40 000	860 000	5%
Western Pacific Region	15 000	170 000	9%
Total	440 000	5 500 000	8%

^a All countries except those in western Europe, the United States, Canada, Australia, New Zealand and Japan.

^b This includes people already receiving antiretroviral therapy at the beginning of 2004 plus an estimate of those who will need to start antiretroviral therapy during 2004 and 2005.

1.3 A comprehensive strategic framework

1.3.1 Declaration of Commitment on HIV/AIDS

At the United Nations General Assembly Special Session on HIV/AIDS in 2001, United Nations Member States unanimously committed to scaling up the global effort against HIV/AIDS through a comprehensive response that includes prevention, treatment, care, support, impact mitigation and promoting and protecting human rights.

1.3.2 The Global Health-Sector Strategy for HIV/AIDS 2003–2007

Following the United Nations General Assembly Special Session on HIV/AIDS, the World Health Assembly requested the Director-General of WHO to develop a strategy that would further elaborate on the contribution of the health sector to realizing the targets and objectives of the Special Session's Declaration of Commitment. The resulting Global Health-Sector Strategy for HIV/AIDS 2003–2007, adopted by the World Health Assembly in 2003 (resolution WHA56.30), aims:

- to help the health sector to meet the goals contained in the Declaration of Commitment on HIV/AIDS;
- to advise health ministries and other stakeholders on the core components of an effective health-sector response to HIV/AIDS;
- to support health ministries in developing policy, planning, priority-setting, implementation and monitoring frameworks needed to generate such a response as part of overall national strategic plans;
- to enhance and promote the comparative advantages, expertise and experience that health ministries and other stakeholders can contribute to national strategic planning for HIV/AIDS; and
- to describe the specific actions to be undertaken by ministries of health and WHO to strengthen the health-sector response to the HIV/AIDS epidemic.

The Global Health-Sector Strategy for HIV/AIDS 2003–2007 is based on the premise that the goals set

out in the Declaration of Commitment on HIV/AIDS can only be achieved if the health sector acts firmly and provides the necessary leadership in its areas of responsibility and expertise, within the context of a multisectoral response. Consistent with the Global Health-Sector Strategy for HIV/AIDS 2003–2007, WHO's work on HIV/AIDS focuses specifically on assisting governments and other stakeholders in implementing a coordinated and comprehensive health-sector response to HIV/AIDS incorporating a continuum of HIV/AIDS and related services, including prevention, treatment, care and support. Such a response also needs to include appropriate health system standards, skills mix, supportive policies and enabling partnerships.

1.3.3 WHO's mission and objective

The Declaration of Commitment on HIV/AIDS describes HIV/AIDS prevention as "the mainstay of the response", and prevention remains central to WHO's programme of activities. The focus of work is on the interventions for which the health sector is clearly responsible and that act to create synergy with treatment, care and support and strengthen the health-sector response overall, such as HIV testing and counselling and preventing HIV infection among women and infants. In addition, WHO's prevention efforts focus on targeting vulnerable populations for interventions and expanding the continuum of care for people living with HIV/AIDS to meet their prevention needs as well.

Since September 2003, WHO has accelerated HIV/AIDS activities at all levels of the Organization and in countries in scaling up antiretroviral therapy. Although much important normative work continues to be done, WHO's strong new country focus in HIV/AIDS has resulted in a new mission statement for its work in the area of HIV/AIDS.

WHO's **mission** in HIV/AIDS is: to achieve the highest attainable standard of health for all people by reducing the impact of HIV/AIDS on their lives. We do this by:

- supporting the health-sector response of our Member States
- working in partnership with all actors and partners in this field
- defining and developing effective technical norms and guidance.

WHO's **objective** in HIV/AIDS is: to rapidly scale up access to HIV/AIDS treatment and care while accelerating prevention and strengthening health systems to enable a more effective and comprehensive health-sector response.

1.3.4 The "3 by 5" Initiative

Treatment has been the most neglected element within a comprehensive health-sector response to the HIV/AIDS epidemic. Increased global funding to support rolling out antiretroviral therapy, together with considerably reduced prices for antiretroviral drugs, growing political commitment and numerous successful pilot initiatives, offer unprecedented opportunities for countries to expand antiretroviral therapy programmes to a national scale. WHO has therefore made a significant effort to increase the human and financial resources available within its overall HIV/AIDS programme to provide the leadership and technical assistance its Member States need to scale up access to HIV treatment and care.

"3 by 5" – treating 3 million people living with HIV/AIDS in developing countries by the end of 2005 – is a target that drives this aspect of WHO's work, rather than a specific programme or unit within the Organization. The "3 by 5" target was based on the analytical work of several scientists before the United Nations General Assembly Special Session on HIV/AIDS. This showed that, with an all-out effort, 50% of those in need of treatment could be reached by the end of 2005.¹ WHO adopted the target in the belief that only by working towards a measurable, time-limited target of this kind would the Organization and the global community act with the urgency necessary for millions of lives to be saved. WHO is encouraged by the commitment of the UNAIDS Secretariat and Cosponsors and of many other organizations to realizing "3 by 5".

The "3 by 5" strategy document,² launched in December 2003, provides an initial strategic framework to show what WHO proposed to do to help realize the "3 by 5" target. WHO activities were grouped under five strategic pillars:

- global leadership, strong partnership and advocacy

¹ Schwartländer B et al. Resource needs for HIV/AIDS. *Science*, 2001, 292:2434–2436.

² Treating 3 million by 2005 – making it happen. The WHO strategy. Geneva, World Health Organization, 2003 (<http://www.who.int/3by5/about/strategy/en/index.html>, accessed 25 June 2004).

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- urgent, sustained country support
- simplified, standardized tools and regimens
- effective, reliable supplies of medicines and diagnostics
- rapidly identifying and reapplying new knowledge and successes.

WHO's programme of work to scale up access to antiretroviral therapy has continued to evolve with input from partners and lessons from work being undertaken in countries. In addition to WHO's efforts, 3 million people will be treated in developing countries by the end of 2005 only through concerted, sustained action and unprecedented collaboration by many other individuals and organizations.

WHO's contributions to scaling up antiretroviral therapy as described in *Treating 3 million by 2005 – making it happen* were endorsed by WHO Member States at the World Health Assembly in May 2004 (see Annex 2, World Health Assembly Resolution WHA57.14, in which WHO Member States acknowledge and affirm the importance of treatment and care within a coordinated and comprehensive response to HIV/AIDS that contributes to overall strengthening of health systems).

1.4 Challenges for country-level action

The remainder of this section outlines several challenges WHO Member States now face in translating the global strategic framework described in Section 1.3 into effective responses to HIV/AIDS at the country level.

1.4.1 The “three ones” principles

New resources now available have given rise to an increasing number of partners and actors working in HIV/AIDS at the country level. The United Nations system, donors, technical agencies and governments in developing and transitional countries are increasingly concerned to ensure that their efforts are coordinated and are based on a common strategy, avoid multiple reporting mechanisms and minimize duplication and fragmentation of effort. The “three ones” concept for country-level responses to HIV/AIDS provides a valuable framework for ensuring that resources and effort are harmonized, sustainable and results-based. The principles are:

- one agreed HIV/AIDS action framework that drives the alignment of all partners;
- one national HIV/AIDS coordinating authority with a broadly based multisectoral mandate; and
- one agreed monitoring and evaluation system at the country level.

The “three ones” approach is broad in nature and needs to be applied to a specific country's institutions and responses. Donors, international agencies and governments broadly agree that a significant proportion of international efforts – including the technical expertise and convening mechanisms of the United Nations system at the country level – need to ensure that national efforts to scale up antiretroviral therapy and accelerate prevention align with a “three ones” approach and serve as effective vehicles for multisectoral coordination and partnership. Applying these principles will also contribute to broader strengthening of health systems and facilitate more effective links between development partners.

1.4.2 Strengthening health systems

The recognition that HIV/AIDS can be managed as a chronic disease even in developing countries and that prevention efforts can be even more successful in the presence of robust treatment and care programmes represents a profound shift in the battle against AIDS. Although the opportunities and challenges for effectively responding to HIV/AIDS have never been greater, it is antiretroviral therapy – of all the possible HIV-related interventions – that can most effectively drive the overall strengthening of health systems, and in particular, chronic health care. An increasing number of countries now have national plans for scaling up antiretroviral therapy and are reflecting HIV/AIDS needs in poverty reduction and other development strategies.

Functioning health systems are fundamental to successful, equitable and sustainable delivery of a continuum

of HIV/AIDS prevention, treatment, care, and support. The challenges of scaling up antiretroviral therapy highlight the persistent fragility of health systems overall, attributable both to the impact of the HIV/AIDS epidemic itself and the result of chronic inadequate funding and weak management. This fragility is manifest in weak infrastructure, poorly integrated services and a shortage of personnel fuelled by the ongoing exodus of health workers in many countries from the public to the private health sector and to other countries.

Providing antiretroviral therapy, prevention and other health services along the continuum necessary for a comprehensive health-sector response to HIV/AIDS requires that all levels of the health system are functioning and are working together. In addition to “3 by 5” and the United Nations General Assembly Special Session on HIV/AIDS, broader health objectives – such as the Millennium Development Goals and health for all – can be supported by improving the quality and coverage of HIV/AIDS services. Obtaining greater access to better services requires strengthening human resources planning and management, drug procurement and supply chain systems, financing mechanisms, health facility planning, patient tracking, social and political analysis and community and private sector involvement. HIV/AIDS interventions also need to build on existing health services, infrastructure and experience, such as the extensive national TB control programmes now in place in many countries as well as sexual, reproductive and children’s health services.

Feedback WHO has received from countries indicates the need for broad technical support to strengthen health systems in addition to assistance specifically to accelerate prevention and to scale up antiretroviral therapy, for example, through the WHO country cooperation strategy process. Underpinning the work of WHO is the belief that developing health systems and a comprehensive response to HIV/AIDS require close collaboration between disease areas and development partners, and that scaling up the response to HIV/AIDS – including antiretroviral therapy – is itself a bold effort that can strengthen health systems (Box 1).

Box 1. The HIV/AIDS and Health Systems Platform

A core principle of the “3 by 5” strategy is that scaling up antiretroviral therapy must contribute to the broader strengthening of health systems. In addition, any rapid expansion of services places major demands on existing health systems. The “3 by 5” strategy already addresses several issues related to health systems, but other challenges remain. WHO is therefore establishing an HIV/AIDS and Health Systems Platform to complement the other intense efforts to improve HIV/AIDS prevention, treatment, care and support. A plan will be developed in consultation with partners by September 2004. Its work will be designed to assist people living with HIV/AIDS, providers, programme managers and policy-makers in overcoming major health system obstacles to improved HIV care and to anticipate, detect and respond to the implications focused activities have for the rest of the health system. In addition to being designed as a critical complement to the short-term target of “3 by 5”, the Platform foresees its work extending well beyond 2005.

1. Individuals and households

Antiretroviral therapy is life-long, and efforts to rapidly expand coverage mean that novel delivery approaches are being used. The Platform will help to ensure that attention is maintained on care provided to marginalized groups. It will work to ensure a focus on patient safety, help to develop policies to ensure that having access to antiretroviral therapy does not place individuals and households at financial risk and monitor trends in catastrophic levels of health care spending by households.

2. Provider organizations and services

Little is known about how to scale up health services rapidly on a nationwide, equitable and sustained basis, especially when existing services are limited and of low quality. Drawing on the experience of other priority interventions, the Platform will examine the lessons learned from different approaches to enhancing service delivery. Antiretroviral therapy will be expanded in facilities in the context of increased resources, and this will place huge demands on management and administrative capacity. The Platform will examine innovative ways to strengthen facility and district management, and in collaboration with the International Alliance on Patient Safety, will support the development of patient safety strategies and monitoring systems that are feasible in resource-limited settings.

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3. Policy options for human resources and health financing

The Platform will support countries in developing financing and human resource strategies for scaling up care for HIV/AIDS while thinking through the implications for the rest of the health system. It will develop or harmonize tools that a) track overall and disease-specific national and external expenditure; b) estimate the costs of scaling up and of including HIV treatment in benefit packages; and c) assess, project and plan workforce needs for HIV/AIDS within a setting of overall development of the health workforce. It will synthesize evidence on: how well various forms of financing protect people from the financial risks of illness and ensure access to services, including antiretroviral therapy; how to ensure sustainable financing; and how to address workforce imbalances, migration, motivation and the effects of political and macroeconomic influences on human resource policies.

4. Scaling up HIV/AIDS care: the implications for the rest of the health system

Governments need a strategic overview of trends in health and health services across the whole system to reconcile competing demands for resources, protect vulnerable people and ensure accountability. This is a particular challenge when private providers are a major source of care. The Platform will contribute to efforts to strengthen country health information systems by:

- developing a core set of indicators or health system metrics that can be used to monitor the strength and performance of health systems;
- helping countries to link the monitoring of HIV/AIDS scale-up with national processes of monitoring progress towards achieving Millennium Development Goals and to integrate equity concerns into monitoring systems; and
- evaluating the system-wide effects of scaling up, to better understand both what worked and why.

1.4.3 Addressing social challenges

Several persistent social challenges need to be tackled in scaling up HIV/AIDS interventions at the country level. These challenges need to be addressed by many actors, in numerous ways and on many fronts, most especially through more vigorous and sustained political commitment at the country level to realizing the rights to health, to information and to freedom from discrimination. This section briefly describes some of those challenges and WHO's contributions to addressing them.

Stigma and discrimination

The Declaration of Commitment on HIV/AIDS provides that, by 2003, all countries will have enacted, strengthened or enforced legislation to prevent discrimination against people living with HIV/AIDS and against vulnerable populations. Nevertheless, by mid-2003, only 62% of United Nations Member States had laws and policies in place to protect people living with or affected by HIV/AIDS against discrimination.³ Substantially fewer (38%) had policies that prohibit discrimination against vulnerable populations. The stigma associated with HIV/AIDS continues to impede effective national responses to the epidemic, underscoring the importance of immediate action by countries to enact and enforce the anti-discrimination policies provided for in the Declaration of Commitment on HIV/AIDS.

Although wider access to antiretroviral therapy will itself help to significantly reduce stigma and discrimination, additional efforts are required to ensure uptake of testing and treatment, for example, by further mobilizing communities, improving the knowledge and attitudes of health care providers and undertaking broad-based communication initiatives as part of national scale-up plans. WHO will increasingly emphasize these approaches through policy guidance and education material,⁴ initiatives for training health providers and communication efforts related to HIV/AIDS.

³ General Assembly of the United Nations. Progress towards implementation of the Declaration of Commitment on HIV/AIDS. New York, United Nations, 2003 (Report of the Secretary-General, A/58/184).

⁴ Understanding and responding to HIV/AIDS-related discrimination in the health sector. Washington, DC, Pan American Health Organization, 2003 (<http://www.paho.org/English/AD/FCH/AI/stigma.htm>, accessed 25 June 2004). HIV/AIDS: stand up for human rights! Geneva, World Health Organization, 2003 (http://www.who.int/hhr/news/en/cartoon_%20complet.pdf, accessed 25 June 2004).

Involving communities and people living with HIV/AIDS

In the Declaration of the 1994 Paris AIDS Summit, countries committed to increasing the involvement of people living with or affected by HIV/AIDS in national responses. WHO ensures that organizations of people living with HIV/AIDS and representatives of affected communities are represented on its partnership forums and other bodies. Models of care and prevention at the country level promoted by WHO highlight the importance of delivering treatment and care for HIV/AIDS through primary health care approaches, taking account of the important role of people living with HIV/AIDS and communities in advocacy, treatment preparedness and literacy and planning and delivering antiretroviral therapy programmes (for example, as expert patients) and in monitoring and evaluating services. Finally, WHO is reviewing health insurance and workplace issues to address the needs of people living with HIV/AIDS in the WHO workforce.

Ethics and equity

The fact that HIV/AIDS does not affect everyone equally and the fact that the need for treatment and care often exceeds the current ability to deliver it means that some people will receive treatment and others will not. Such a situation poses serious ethical issues for governments, international agencies, nongovernmental organizations, groups of people living with HIV/AIDS, institutions and health care workers. The most compelling of these ethical dilemmas involve choices that will affect the life and death of millions of people. This set of circumstances imposes powerful ethical obligations to deliver treatment in ways that are as fair, beneficial, and sustainable as possible.

Some of the questions that arise include the following. Should some population groups be given priority in access? To what extent should considerations of fairness constrain another objective of public health intervention: maximizing the benefits produced? How can fair processes (such as ones that are transparent, participatory and revisable) in making these difficult decisions be assured?

To support the countries in making the difficult decisions involved, WHO is preparing guidance on the ethical and equitable scaling up of treatment and care for HIV/AIDS. In January 2004, a WHO/UNAIDS Consultation on Equitable Access to Care for HIV/AIDS took place at WHO headquarters in Geneva, involving a wide range of stakeholders including human rights experts, people living with HIV/AIDS, philosophers, community-based organizations and programme managers from all WHO regions. The report of the consultation as well as three background papers provide an overview of the issues.⁵ The interim guidance document is intended to be useful for government officials, programme administrators at the district and local levels, community-based and nongovernmental organizations, groups of people living with HIV/AIDS and international and donor agencies. It will be revised periodically in light of emerging evidence.

Training materials are also being developed and case studies of best practices collected. These illustrate both the ethics and equity norms for antiretroviral therapy programmes and fair processes for the development of policies within countries. Indicators to measure outcomes and fair decision-making processes are also being developed. Finally, WHO is working with its partners to identify how country-level monitoring of antiretroviral therapy programmes can most effectively measure equitable outcomes, for example by disaggregating data on gender, age, socioeconomic status and marginalization.

Gender

Women and girls now account for 50% of people living with HIV/AIDS globally and 58% of people living with HIV/AIDS in sub-Saharan Africa. These trends are most pronounced among young people. Women and girls are becoming increasingly vulnerable to HIV infection and bear the overwhelming burden of AIDS care, both informally in their families and communities and through the formal care sector. Programmes need to recognize and respond to the variety of ways in which gender inequity exposes women and girls to the risk of HIV infection, undermines women's access to services and programmes and entrenches the inequitable situation of women. A gendered approach to addressing this inequity needs to involve men and women and advocacy for a legislative and policy environment that promotes the rights of women.⁶

⁵ World Health Organization and UNAIDS. Consultation on Equitable Access to Treatment and Care for HIV/AIDS, 26–27 January 2004. Summary of issues and discussion. Geneva, World Health Organization (in press).

Macklin R. Ethics and equity in access to HIV/AIDS treatment. Geneva, World Health Organization (in press).

Daniels N. How to achieve fair distribution of ARTs in "3 by 5": fair process and legitimacy in patient selection. Geneva, World Health Organization (in press).

"3 by 5", priority in treatment, and the poor. Geneva, World Health Organization (in press).

⁶ Draft Code of Good Practice for NGOs responding to HIV/AIDS, International Federation of Red Cross and Red Crescent Societies, 2004 (<http://www.ifrc.org/what/health/hivaids/code>, accessed 25 June 2004).

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The development of national responses needs to closely address gender issues – including attention to the roles and responsibilities of men and measures to empower women and girls, to improve their socioeconomic status, to reduce stigma and discrimination and to enhance their access to HIV/AIDS prevention, treatment, care and support. A growing body of evidence shows that community-driven interventions help to improve access by women and girls to health care and psychosocial support.

The collective stock of knowledge about the gender-related determinants of risk, vulnerability and barriers to service utilization by women and girls has grown over the past decade, but putting that knowledge to practice remains a formidable challenge for policy-makers and implementers across all sectors. WHO is committed to contributing through its HIV/AIDS programme to improving the health and social outcomes for women and girls and to working with all necessary partners – such as women living with HIV/AIDS, nongovernmental organizations, the United Nations–sponsored Global Coalition on Women and AIDS and national governments⁷ – to further this objective.

Specifically, WHO will work to ensure that programmatic entry points to treatment appropriate for women and girls are strengthened, such that HIV testing and counselling with links to treatment programmes are established in settings such as reproductive health, including family planning and maternal and child health services, and in home care programmes that might serve women.

WHO will strongly advocate with all governments, donors and partners that the global target for the numbers of women receiving antiretroviral therapy should be in accordance with the epidemiological profile of the disease and will assist individual countries in setting appropriate targets for both women and children. Accordingly, WHO's monitoring and evaluation tools and support to countries will continue to be designed to ensure that countries collect information that allows them to understand the nature of their epidemic according to gender, age, geography and risk group and to use these variables to predict treatment needs and monitor the progress of their treatment, care and prevention programmes.

⁷ Integrating gender into HIV/AIDS programmes: report of an expert consultation, 3–5 June 2002, Geneva, Switzerland. Geneva, World Health Organization, 2002 (http://www.who.int/hiv/pub/prev_care/gen/en, accessed 25 June 2004).

2. WHO HIV/AIDS programme, 2004–2005

2.1 Introduction

This section describes the WHO HIV/AIDS programme for the 2004–2005 biennium. It begins by describing the comparative advantages on which the functional activities are based. The five functional areas of the WHO programme budget for 2004–2005 are then described (Section 2.3), including key outcomes and indicators, together with illustrative examples of the priority activities to be undertaken in each functional area. Sections 2.4, 2.5, and 2.6 focus on the three areas that provide the specific content for: scaling up antiretroviral therapy, scaling up care and support and accelerating HIV/AIDS prevention.

2.2 Comparative advantages

Article 2 of WHO's Constitution specifies the Organization's mandate to serve as the "directing and coordinating authority on international health work" and in so doing, to assist governments and to provide technical assistance (Annex 3). World Health Assembly resolutions WHA55.12, WHA56.30 and WHA57.14 define the scope of WHO's HIV/AIDS work.

WHO works within the family of UNAIDS Cosponsors to facilitate multisectoral efforts within the United Nations system. As part of its broad health-sector mandate in HIV/AIDS, it specifically serves as the convening agency within the United Nations system for HIV/AIDS treatment, care and support as well as for preventing the mother-to-child transmission of HIV. WHO works closely with the UNAIDS Secretariat and Cosponsors at the global level and in countries with cosponsoring agencies through the United Nations country theme groups on HIV/AIDS.

The roles WHO will perform as described here are consistent with WHO's overall mandate and the expectations expressed by the Organization's partners at a meeting in Geneva, Switzerland in May 2004.

Support and advisory role with health ministries and national governments

WHO has a close relationship supporting and advising health ministries in Member States at their request. WHO's relationships with ministries and other parts of government allow it to raise and negotiate a broad range of technical and policy issues. This is especially important given the changes implied by the paradigm shift of scaling up antiretroviral therapy, which presents new challenges to the health sector.

Convening and coordinating partner efforts in scaling up treatment, care and prevention

Country-level experience indicates that WHO could be well positioned to coordinate action and inputs from many stakeholders and to ensure that such inputs are organized into a cohesive scale-up of health-sector responses. In countries, this includes active involvement in the United Nations country theme groups on HIV/AIDS and close cooperation with the UNAIDS Secretariat, UNAIDS cosponsors and other United Nations agencies to help coordinate United Nations action at the country level.

Technical expertise

WHO's expertise in technical guidance covers the array of health system issues related to scaling up antiretroviral therapy and accelerating prevention. This includes simplified treatment regimens, testing and counselling, capacity-building (tools and training), models for scaling up antiretroviral therapy, laboratory requirements, drug procurement and supply chain management, human resource planning and management, surveillance, monitoring and evaluation, outreach to vulnerable populations, programme communication, operations research and the general development of health systems. WHO continues to receive many requests for technical assistance from Member States in all these areas. WHO also plays a valuable role in providing policy guidance in a variety of related areas such as ethics, community involvement and strengthening and financing health systems.

Planning

WHO assists governments and other stakeholders in developing national implementation plans for health-sector interventions, including scaling up antiretroviral therapy, in accordance with the “three ones”.

Strategic information management and reporting

WHO has long undertaken the role of identifying, collecting and synthesizing information in many areas of health. This information includes epidemiological data, information on the type and availability of health services (which is geographically mapped) and information on health systems. WHO is working to align key partner organizations in supporting a standard set of HIV/AIDS monitoring and evaluation measures to be collected at the country level to eliminate redundant effort and optimize the use of resources.

Global support for high-quality drugs and diagnostics

WHO can make a range of contributions in supporting efficient processes of global and national drug procurement and supply chain management. The unique WHO prequalification process allows manufacturers to have their products certified by an independent panel of experts following an internationally endorsed process. This enables countries to source these products for use while being assured of drug quality. The new AIDS Medicines and Diagnostics Service (AMDS) – a joint initiative of WHO, the United Nations Children’s Fund (UNICEF), the World Bank, the United Nations Development Programme, the UNAIDS Secretariat and other partners⁸ – will synergize the delivery of an array of additional services to improve access to HIV drugs and diagnostics at the country level. When fully operational, AMDS will be an indispensable resource to countries, acting as a clearing house for information such as drug prices and the regulatory and patent status of all medicines related to antiretroviral therapy. AMDS will provide direct technical support to all countries and will assist in developing detailed supply management plans in 40 countries by the end of 2005. AMDS will work to reduce antiretroviral and diagnostic prices by standardizing treatment, by assisting in price negotiations and by helping countries to pool demand and leverage their collective scale.

Operations research and learning through experience

WHO’s knowledge of health-sector responses and health systems performance allows it to guide and inform operations research and the design and implementation of surveillance, monitoring and evaluation systems. WHO will work with countries to collect and analyse data on key operational questions, such as integrating antiretroviral therapy into existing health services and providing preventive and therapeutic interventions along a continuum of care. Lessons learned from scaling up will be rapidly and widely disseminated.

Assisting countries in mobilizing resources

WHO has knowledge and expertise in mobilizing funds at the country, regional and global levels, including developing proposals to the Global Fund to Fight AIDS, Tuberculosis and Malaria and other major foundations and developing project plans for World Bank support. Special efforts will continue to be made to assist countries in developing proposals in all three disease areas supported by the Global Fund to Fight AIDS, Tuberculosis and Malaria. For example, in Round 4, WHO assisted 22 countries in developing proposals to support scaling up antiretroviral therapy. WHO can also assist both countries and granting agencies in expediting the distribution and implementation of resources.

Advocating for a comprehensive response to HIV/AIDS

Given its close relationship with Member States, WHO can work with governments to ensure that appropriate political will and commitment to HIV/AIDS programmes are sustained.

Leveraging WHO’s organizational capability

WHO’s global, regional and country presence, as well as its technical and human resources, represent a major resource pool for countries. Finding ways to better leverage total organizational capability at its various levels to fight HIV/AIDS represents a major opportunity for WHO as a whole to modernize, integrate and be more responsive to country needs.

⁸ AMDS will be a network hub model helping to coordinate the many ongoing efforts to improve procurement and supply chain management. With a coordinating secretariat based at WHO, the technical work of AMDS will be mainly carried out in collaboration with UNAIDS Cosponsors and other partners. AMDS is strongly linked to the Interagency Pharmaceutical Coordination Group (a partnership between WHO, UNICEF, the World Bank, the United States Agency for International Development and the United Nations Population Fund).

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HIV/AIDS technical staff work collaboratively with those in many other parts of WHO. New ways to leverage existing capabilities are being explored, such as using WHO staff working in polio or TB at the country level to accelerate the scaling up of antiretroviral therapy.

Identifying gaps and seeking solutions

As health-sector interventions are scaled up at the national level, new challenges will emerge and gaps in the response will need to be filled by developing new tools, partnerships and policies. Although WHO will not necessarily lead activities in all cases, it plays a valuable role in monitoring these gaps and in identifying solutions and working with others – especially UNAIDS Cosponsors – to develop them.

2.3 HIV/AIDS Area of Work for 2004–2005

The HIV/AIDS area of work contained in the 2004–2005 programme budget for WHO identifies a set of five expected results. Consistent with the 2004–2005 programme budget framework, HIV/AIDS activities are grouped into five functional areas: strategic information; advocacy and policy; technical and normative guidance; country capacity-building; and operations research and knowledge management.

2.3.1 Strategic information

Comprehensive HIV/AIDS responses, including scaling up efforts for treatment and prevention, require accurate and timely information. WHO is regarded as an important source of global surveillance information, for example, in developing, implementing and operating second-generation surveillance systems, which include HIV/AIDS, sexually transmitted infections and behavioural data. WHO also focuses on developing tools and guidelines for mapping, monitoring and evaluating health-sector interventions and building capacity for monitoring and evaluation. This area of work requires close collaboration with international partners and the guidance of the WHO representative in each country, who helps to ensure that data are consistent across the health sector, are nationally owned and reflect country needs.

Expected results

- Comprehensive and reliable national and global mechanisms for HIV monitoring and evaluation, including surveillance, formulated or in place
 - o Indicators: (1) number of targeted countries that conduct systematic, standardized surveillance in identified priority populations, including surveillance of behaviour and patterns of antiretroviral drug resistance; (2) number of evidence-based reviews to support strategies
- Comprehensive and reliable information available to support the country-level procurement of drugs and diagnostics
 - o Indicator: number of country procurement and supply management profiles developed
- Comprehensive and reliable information on country-level activities for scaling up antiretroviral therapy
 - o Indicator: number of “3 by 5” country profiles developed

Illustrative activities

- Providing leadership and harmonization of technical tools and guidance and capacity-building related to monitoring and evaluation, including HIV/AIDS, sexually transmitted infections and behavioural surveillance
- Mapping HIV/AIDS service coverage, delivery points and programme scale-up, including priority factors as needed, such as programme impact, equity and antiretroviral therapy adherence
- Conducting surveillance and monitoring of HIV drug resistance, including acting as the secretariat for HIVResNet, a global network of HIV drug resistance scientists that is the primary partner in

developing global standards, guidelines, definitions and reports relating to antiretroviral drug resistance (Box 2)

- Establishing a data clearing house on antiretroviral drugs and diagnostics, including acting as the secretariat for AMDS, which will develop country-specific information on drugs and diagnostics (such as sources of technical assistance, prices, patents, suppliers, warehousing and distributors), collect global-level information on patents and the regulatory status of antiretroviral therapy and diagnostics and disseminate models and methods for procurement and supply chain management.

Box 2. WHO's strategy for minimizing HIV drug resistance through good practices, surveillance, and monitoring

Because HIV has a very high mutation rate, and because antiretroviral therapy should be continued for life once it has begun, HIV drug resistance will emerge to some degree among people in treatment even if appropriate antiretroviral therapy is provided and adherence is supported. However, well-functioning antiretroviral therapy programmes can minimize the emergence of HIV drug resistance and its transmission. WHO seeks to promote practices to minimize the emergence and transmission of HIV drug resistance and to reduce its public health consequences. The public health principles for minimizing HIV drug resistance are:

- ensuring appropriate antiretroviral drug access, prescribing and use
- promoting adherence
- supporting the prevention of HIV transmission
- taking appropriate action based on monitoring and surveillance.

WHO is the secretariat for HIVResNet, a global network of laboratory technicians, clinicians and epidemiologists. HIVResNet was formed to support and implement standardized methods for HIV resistance surveillance and monitoring. Current plans include the implementation of an international laboratory quality assurance system to support regional networks and international partnerships for genotyping HIV drug resistance. In-country databases for HIV drug resistance surveillance and monitoring, which could contribute data to a global database housed at WHO, are also being developed.

WHO's plan for HIV drug resistance surveillance and monitoring has three elements:

- monitoring antiretroviral therapy programmes for appropriate prescribing practices, support of adherence, clinical outcomes, drug supply and prevention measures;
- estimating transmitted HIV drug resistance by testing specimens from HIV serosurveys or diagnostic centres through HIV drug resistance threshold surveys and representative sampling; and
- monitoring patterns of HIV drug resistance emerging at 12 and 24 months among cohorts of people starting their initial antiretroviral therapy regimen.

Information will be used to monitor the continuing utility of standard regimens used within the country and to guide public health action to support the minimization of HIV drug resistance. With HIVResNet and other international partners and sufficient funding, WHO plans to collaborate with up to 20 countries to begin monitoring and surveillance of HIV drug resistance in the coming year. Draft guidelines have been published (<http://www.who.int/3by5/publications/documents/hivdrugsurveillance/en>, accessed 25 June 2005) and will be updated regularly.

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2.3.2 *Advocacy and policy*

Scaling up a comprehensive health-sector response to HIV/AIDS including antiretroviral therapy and accelerating prevention efforts requires health system leadership, coordination, innovation and partnership. Several issues related to advocacy, health policy and systems development must be addressed to advise and guide decision-makers on the best approaches to scaling up.

Expected results

- Countries will be supported in developing and implementing national plans for scaling up and implementing antiretroviral therapy in accordance with the “3 by 5” target
 - o Indicators: (1) number of countries with national plans for scaling up; (2) number of countries with national plans for scaling up in accordance with “3 by 5” targets
- HIV/AIDS advocacy and strategic planning enhanced by promoting and developing multisectoral partnerships
 - o Indicators: (1) number of countries incorporating recommendations and core health-sector interventions from the Global Health-Sector Strategy for HIV/AIDS 2003–2007 into national plans; (2) number of strategic collaborations and partnerships supported by WHO
- Countries supported in developing and implementing successful funding proposals
 - o Indicator: annual increase in the success rate of WHO-supported funding proposals
- Countries supported in strengthening health systems through technical support for physical infrastructure planning, upgrading laboratory services, transport, information technology and clinics and through accreditation of service delivery points
 - o Indicators: (1) number of countries with comprehensive physical infrastructure plans; (2) number of countries that have introduced WHO-supported accreditation of service delivery points

Illustrative activities

- Developing and implementing strategic advocacy and communication products for targeted outreach, including donors, nongovernmental organizations and mass media: communicating messages through events, news updates, web sites, video, photographs, information materials and publications
- Undertaking advocacy and providing global policy guidance in key areas, including planning, financing, service delivery, ethical issues, equity, human resources, health systems development, HIV/AIDS in emergency settings, models for scaling up, outreach to vulnerable populations, private sector and community participation, drug pricing (including second-line regimens), and working with countries to adapt these to national settings

2.3.3 *Technical and normative guidance*

Normative work will continue in key thematic areas, building on the rapidly evolving knowledge base and addressing issues critical for effectively designing and implementing programmes.

Expected results

- Technical and normative guidance developed and provided to countries to enhance essential HIV prevention, treatment, care and support services and interventions

- o Indicator: number of targeted countries using and/or adapting WHO tools on the management of HIV and related conditions, including tuberculosis and sexually transmitted infections, and on the procurement, manufacture, regulation and appropriate use of HIV-related drugs and diagnostics

Illustrative activities

- Developing technical and operational guidelines in priority areas, such as:
 - o The clinical use of antiretroviral therapy, with further attention to mother-to-child transmission and special groups such as women, children and injecting drug users
 - o Integrating testing and counselling and antiretroviral therapy in various health care settings (including TB care, inpatient and outpatient health care, antenatal care, child health, services for sexually transmitted infections, harm reduction services for injecting drug users and scaling up antiretroviral therapy in district and primary health care services)
 - o HIV diagnosis among infants and young children and related family-based counselling
 - o Use of rapid HIV tests and related counselling
 - o Counselling and support for people on antiretroviral therapy, including adherence and prevention
 - o Integrating communication initiatives into HIV/AIDS testing, prevention, care and treatment programmes
 - o Surveillance, monitoring and evaluation
- Prequalifying HIV-related drugs and diagnostics, maintaining a Model List of Essential Medicines and providing technical guidance on drugs and diagnostics procurement and supply management through AMDS

2.3.4 Country capacity-building

Programmes are only sustainable in countries if resources are invested in long-term capacity-building. WHO's focus is on linking the activities and technical assistance of each of its organizational levels to country needs. WHO will actively support putting the "three ones" framework into operation. Of the five functional areas in this section, the largest proportion of the WHO budget is dedicated to country capacity-building activities (shown in Table 7 later in the document).

Expected results

- Countries will be supported in building national capabilities and technical expertise for improving health system responses to HIV/AIDS, including planning and setting priorities; allocating and managing resources; and delivering and evaluating services and interventions
 - o Indicator: number of targeted countries building competencies in HIV/AIDS in the health sector, including uptake of WHO normative tools and resources
- The involvement of communities in delivering HIV prevention, care, support and treatment will be enhanced
 - o Indicator: number of strategic collaborations and partnerships supported that involve civil society organizations and people living with HIV/AIDS
- Human resources to deliver HIV services will be strengthened in countries by developing and implementing training, certification and strategies for rapidly disseminating knowledge
 - o Indicators: (1) number of countries that have introduced training using WHO-supported certification of competence; (2) number of health providers and community treatment providers trained in delivering antiretroviral therapy services
- Supply chain management and procurement of diagnostics and antiretroviral drugs will be improved
 - o Indicator: number of countries using support from AMDS for procurement, manufacturing and supply management of antiretroviral drugs and diagnostics

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Illustrative activities

Technical support

- Providing technical support to countries for policy development, strategic planning and adaptation of technical and operational guidelines in all key programme areas

National capacity-building

- Strengthening WHO country offices to provide improved country support, consistent with the WHO country cooperation strategy in each country, including recruiting dedicated HIV/AIDS staff
- Strengthening WHO's participation in in-country mechanisms, such as United Nations country theme groups on HIV/AIDS and country coordinating mechanisms, to support coordination, planning and the mobilization of resources
- Supporting national health-sector planning on HIV/AIDS, including scaling up antiretroviral therapy
- Supporting national institution-building, such as national HIV/AIDS resource centres or knowledge hubs and regional networks
- Strengthening the capacity of countries to conduct research and monitoring and evaluation, including monitoring and evaluating the quality, coverage and effectiveness of the scaling up of antiretroviral therapy and the impact of scaling up on the development of health systems
- Supporting initiatives to mobilize communities and to increase preparedness for treatment

Human resources development

From a country perspective, major bottlenecks in successfully responding to human resource challenges in the health sector include (1) the absence of a concerted human resource strategy to recruit, train and retain the workforce necessary to deliver antiretroviral therapy; (2) the use of multiple training materials; (3) weak training capacity; (4) insufficient quality control and certification systems in the training sector; (5) lack of financial resources for training; and (6) poor coordination and segmented approaches to training.

The WHO capacity-building plan aims to support countries in overcoming these barriers to ensure both the emergency expansion of the HIV/AIDS workforce and the long-term sustainability of human resources in the health sector (Table 2).

Table 2. Elements of the WHO plan for human resource capacity-building

	Countries	Regions	Global
Human resources planning	Support the development of one country human resource and training plan	Technical resource networks and regional guidance for human resource assessment and planning	Shared understanding of tools and guidelines for human resources planning among key technical, donor and academic institutions; development of core guidance
Developing training materials	Training material appropriate to a national scaling-up approach for all key staff involved in scaling up antiretroviral therapy, with a focus on facility-level training based on the WHO Integrated Management of Adult and Adolescent Illness module	Technical assistance in developing national training materials through regional technical resource networks and knowledge hubs, including technical networks related to the WHO Integrated Management of Adult and Adolescent Illness	Partner consensus on training packages, outlining core competencies, curricula and annotated training material for different types of health workers, with a focus on facility-based interventions
Capacity of training providers	Appropriate pre- and in-service training capacity with a focus on district and first-level training	Providing opportunities for training trainers and providing in-country support to build capacity among training providers based on training packages (including training based on the WHO Integrated Management of Adult and Adolescent Illness approach) through resource networks and knowledge hubs	Developing partnerships to support the development of technical resource networks at the regional level
Certification and quality control	National systems for certification of health workers involved in scaling up antiretroviral therapy	Technical assistance in establishing certification systems through technical resource networks	Recommendations and partner consensus on the criteria for process, content and outcome verification for developing national certification systems
Financial resources	Training and human resource needs appropriately reflected in funding plans and proposals	Regional back-up to the development of national funding plans and proposals	Facilitation of access to global funding through guidance notes and case-by-case assistance

2.3.5 Operations research and knowledge management

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Learning by doing is critical to rapidly scaling up HIV/AIDS programmes. WHO can play a role in helping to identify priorities in operations research and in integrating operations research into service delivery. WHO can also be actively involved in an innovative process of information and knowledge management to rapidly improve practices and interventions, for example, by improving information systems and promoting best practices accessible at the country level.

Expected results

- A dynamic and relevant global agenda and innovative partnerships will be stimulated for research, including operations research on scaling up treatment and accelerating prevention and research on drug resistance, vaccine and microbicide development
 - o Indicator: number of research initiatives strengthened through WHO mechanisms or participation

Illustrative activities

- Formulating a global operations research agenda and identifying the key partnerships needed to implement it, with possible priority areas including:
 - o Integrating antiretroviral therapy into existing infrastructure and programmes, including links with maternal and child health, reproductive and sexual health, TB control programmes and services for drug users
 - o Comparing models of prevention, treatment, care and support, including innovative models of supporting adherence and programmes to reach out to vulnerable populations
 - o Maximizing synergy between preventive and therapeutic interventions
 - o Optimizing the contributions of the private sector, communities and people living with HIV/AIDS to service delivery, including the role of people on antiretroviral therapy as expert patient trainers, treatment supporters and clinic staff; quality assurance; equity of access to services; adherence and its impact on transmission; and the social and systemic impact of programmes
 - o The use and acceptability of rapid HIV testing, especially among marginalized groups
- Knowledge management systems, especially for data on country scale-up: linking countries engaged in scaling up through an information network that shares innovations and insights from the field in real time, including progress against standard indicators
- Identifying and reapplying learning by disseminating best practices in programme design and delivery

2.4 Scaling up antiretroviral therapy

2.4.1 Overview

Through its intelligence-gathering efforts, WHO is building significant knowledge on scaling up antiretroviral therapy at the country level – both current and planned. The exact roles that WHO will play in each country in supporting scale-up will be based on a thorough analysis of the situation at the country level, in collaboration with governments and partners. Partners with specific expertise or comparative advantages may fill some roles better, in which case WHO is prepared to play a strong brokering or convening role. Scaling up should be understood in the broadest sense to include not only the logistics of procuring and supplying drugs but also core related activities such as financing, training of health providers, developing enabling policies and regulations and developing appropriate health infrastructure.

This section describes in general terms the major barriers identified in efforts to scale up antiretroviral therapy at the country level, together with the contribution WHO will make to addressing them. It also outlines how WHO's country assessment and data-gathering processes will guide the development of detailed country work plans.

2.4.2 Overcoming barriers to scaling up

Country contexts and barriers and opportunities for rapidly and sustainably scaling up antiretroviral therapy are increasingly well understood as a result of improved country mapping, staff deployment and interaction with partners.

Experience to date indicates that countries are currently struggling with several obstacles and challenges that serve as roadblocks to progress in scaling up national responses. However, numerous opportunities also exist to move ahead. This section highlights these obstacles and opportunities and outlines what WHO will do to help address them.

National political commitment and an enabling policy environment

- Some countries have inadequate overall political commitment.
- Competing government structures and stakeholders result in poor national coordination.
- Some countries have no national antiretroviral therapy policy or strategy or antiretroviral therapy component in the national HIV/AIDS strategy.
- Antiretroviral therapy guidelines and protocols are inadequate or need updating.
- Policies on the choice of antiretroviral therapy regimen or drugs (fixed-dose combinations – proprietary or generic) need to be developed.
- Regulations restrict the type of health care workers and/or services that can provide treatment follow-up and drug prescription (such as limited to AIDS treatment centres).
- Antiretroviral therapy provided through the private sector is regulated poorly or not at all.
- Access to antiretroviral therapy is inequitable among women, children, poor people, vulnerable groups, health workers and displaced people and in remote areas and emergency settings.
- Policies limit access to effective drug dependence treatment (such as the availability of methadone).
- Some confusion exists on targets for scaling up antiretroviral therapy (aligning national, WHO and donor targets).
- Legal, social and systemic barriers prevent access to services by marginalized populations such as drug users, sex workers, prisoners, displaced people and undocumented people, and community and political support for providing services to such populations is often lacking.
- Stigma and discrimination continue to dissuade people from seeking testing and/or treatment.

WHO will: intensify advocacy efforts to encourage high-level political support in countries; encourage national leadership and ownership; continue advocacy among global partners to encourage broad support for the “3 by 5” target and scaling up antiretroviral therapy; adapt tools and guidelines to country needs; undertake advocacy and provide technical support for the development of enabling legislation; engage partners to ensure efforts to reduce stigma and discrimination, including training of health care providers and greater use of expert patient trainers; provide technical guidance to support improved programme communication and outreach; and support monitoring and evaluation to improve programme quality, acceptability and accessibility.

Funding

- Funding gaps exist for drug supply and technical assistance at the country level.
- More resources are needed at the country level to support the procurement and distribution of drugs and diagnostics.
- Resources could potentially be diverted from other programmes.
- Existing resources are used inefficiently and efforts are duplicated.
- Funding, financing and donor agencies coordinate and cooperate poorly with technical support agencies.
- Investment in sustainable responses is lacking, such as national institution-building.
- In many cases, funds granted to date have not been distributed.

WHO will: work with countries to develop integrated strategies for mobilizing resources that raise funds for scaling up at the global, regional and country levels; provide technical support to countries to enable them to plan, reallocate internal resources and mobilize external resources; map country input to facilitate donor coordination; develop costing tools and assist with country-specific financial analysis; and work with funding organizations to expedite the flow of granted funds to countries.

Supply of drugs and diagnostics

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- The prices of drugs and diagnostics remain high in some countries, often as a result of intellectual property issues.
- Drug regulation, procurement mechanisms and supply chains are weak in some countries.
- Storage and security of commodities needs to be improved.
- Concerns persist about drug quality.
- Laboratory facilities are weak or nonexistent.

WHO will: engage with governments and industry to promote lower drug prices; work through multilateral trade agreements to find solutions to intellectual property and trade-related issues; ensure that quality-assured, fixed-dose combination drugs have regulatory approval in all key countries; provide technical support through AMDS, including an information clearing house and country mapping and capacity-building.

Development of health systems

- Human resources and capacity-building need to be strengthened to overcome a lack of comprehensive strategies and policies on human resources, insufficient skills and personnel and a lack of training materials.
- Staffing regulations are inadequate: for example, due to recruitment limitations.
- Staff are not retained because of factors such as illness, burnout, low pay and more attractive conditions in other countries or sectors.
- Capacity-building activities at the national level are weakly coordinated (such as an absence of a training strategy and plan).
- The numbers and skills of trainers of staff are inadequate.
- The skills of laboratory personnel are inadequate.
- The quality of tools and support materials for antiretroviral therapy training is poor.
- There is no process of certifying trained staff.

WHO will: support countries in identifying major gaps in health-sector capacity and devise strategies to address them; promote community involvement and empowerment; provide technical support for developing capacity for managing procurement and the supply chain; develop training tools for health care providers and treatment supporters, in particular for training health workers at first- and second-level facilities based on the WHO Integrated Management of Adult and Adolescent Illness approach (Box 3); develop recommendations on national training certification guidelines and accreditation of health care facilities; and provide technical guidance on scaling up testing and counselling services.

Box 3. Preparing front-line workers: a WHO antiretroviral therapy training package for health workers at first-level facilities

Recognizing the urgency of integrating HIV/AIDS treatment into health services at first- and second-level facilities, WHO and partners have developed a clinical HIV care training package based on the WHO Integrated Management of Adult and Adolescent Illness approach.

The package is based on several simplified, operational guidelines covering *Acute care*, *Chronic HIV care with antiretroviral therapy*, *General principles of good chronic care* and *Palliative care* (<http://www.who.int/3by5/publications/documents/imai/en>, accessed 25 June 2004). These guidelines will support the shift of key tasks from physicians to nurses and health care workers and encourage the involvement of lay providers and the community. The WHO Integrated Management of Adult and Adolescent Illness guidelines have been translated into several readily adaptable training courses for health workers in first-level facilities.

- *Basic antiretroviral therapy clinical training course.* This course prepares nurses, clinical officers or medical assistants to perform a clinical review, undertake clinical staging, provide prophylaxis, prepare patients for adherence, initiate a fixed-dose first-line antiretroviral regimen among people without complications under supervision, consult or refer to district medical officers, respond to side effects, monitor and support adherence, collect data based on a simple treatment card and effectively integrate HIV care and prevention. This course requires 4.5 days of training.
- *Antiretroviral therapy aide training course.* This course addresses HIV basics, including the continuum of care and progression of disease; available treatments; patient education and support; adherence preparation, monitoring and support; communication skills; group education and support; and reception and triage. This course also requires 4.5 days. It can be used with lay providers or staff with limited clinical background.
- *Short course on opportunistic infection management.* This course focuses on the emergency quick check, cough or difficult breathing (pneumonia, TB, and other causes of severe illness), mouth and skin problems, headache and meningitis and peripheral neuropathy. Emphasis is placed on when to suspect HIV infection or TB disease and how to manage less severe opportunistic infections, allowing many people with WHO Stage III and IV HIV disease to be treated prior to antiretroviral therapy without referral to the district.

All materials based on the WHO Integrated Management of Adult and Adolescent Illness approach were developed over time through expert consultation and field application. Effective, rapid processes of country adaptation are recognized to be key for their relevance to countries. For example, Uganda's Ministry of Health has adapted guidelines and training materials based on the WHO Integrated Management of Adult and Adolescent Illness approach. WHO helped to train a national core group of 40 facilitators and 30 expert-patient trainers who are now rolling out training based on the WHO Integrated Management of Adult and Adolescent Illness approach at the district level.

WHO regional offices and headquarters are now setting up regional pools of experts who can provide support to countries in developing and rolling out antiretroviral therapy training all the way to first-level facilities. WHO will continue to learn from in-country application and improve and expand the range of tools available to implementers. WHO has already developed patient education flipcharts and patient treatment cards for each first-line regimen and is developing additional training aids such as videos. Additional materials, such as training courses based on the WHO Integrated Management of Adult and Adolescent Illness approach for district medical officers, are in production.

Training packages based on the WHO Integrated Management of Adult and Adolescent Illness approach are complemented by simplified patient monitoring guidelines that were agreed upon during an international meeting in March 2004. These are based on agreed minimal or essential data elements to be collected during clinical chronic HIV care and antiretroviral therapy to support direct care needs and drug supply monitoring at the facility level and to meet the reporting needs of district and national programmes in accordance with the overall WHO/UNAIDS recommendations.

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Coordination of national responses

- In some cases, national leadership and ownership is weak, resulting in poor coordination at the national and regional levels: for example, weak coordination mechanisms and overlapping responsibilities of units in health ministries, country coordinating mechanisms, “3 by 5” technical working groups, task forces and United Nations country theme groups on HIV/AIDS.
- It is not clear who is responsible or accountable for planning, managing and monitoring the scaling up of antiretroviral therapy programmes.
- Care and antiretroviral therapy units and teams are not yet in place at the national and regional levels.
- Conflicts exist between various government bodies such as the national AIDS control programme and the national AIDS commission.
- There are few best practices in this area.
- Stronger partnership and coordination are needed.

WHO will: support country-led coordination processes; provide technical leadership on the health-sector response; contribute to quickly demonstrating successful scale-up models in countries (Box 4); and develop measures for monitoring progress in coordination.

Box 4. Developing national models for scaling up antiretroviral therapy

Country by country, the numbers of people receiving antiretroviral therapy need to be expanded dramatically. On average, coverage in the 34 countries with the highest burden of disease needs to increase 13 times to achieve the “3 by 5” target, but some countries must scale up by a factor of 20 to 100 in less than two years. The United Republic of Tanzania, for example, needs to increase the number of people being treated from 1650 to 130 000 – a factor of 79.

Each country’s national scale-up plan will need to translate that challenge into local terms, describing the current and planned infrastructures, the structure of the care system, the nature and structure of informal systems of care, drug needs, human resource requirements, training needs and so on. To date, many countries have begun to consider what needs to be done to scale up treatment so rapidly, but few have determined how such scale up can occur in such a compressed period of time.

Although WHO knows well that the details vary, often dramatically, among local settings, WHO – with assistance from the Institute for Healthcare Improvement – has developed one such process for rapidly scaling up the provision of antiretroviral therapy in countries. A separate WHO publication, entitled *An approach to rapid scale-up using HIV/AIDS treatment and care as an example* (in press), provides details of this potential approach.

This approach to scaling up has two major elements:

- a multiplicative model for involving care and treatment sites in successive expansion waves; and
- a real-time interactive operations research method, linked to a collaborative improvement model (called the breakthrough series model by the Institute for Healthcare Improvement), through which all the sites, along with the national team, learn and grow together in their ability and capacity.

It is hoped that publication of this potential approach to exponential scale-up of antiretroviral therapy will provoke thinking throughout the HIV/AIDS community about the need for and application of such a model. WHO is not advocating any particular approach but is simply signalling the need for exceptional thought and action to reach so many people in need of treatment in such a short period of time.

Planning for scaling up

- National operational plans have not yet been developed or the necessary input from all stakeholders and partners has not been obtained.
- More work is needed in programming and implementing scale-up: agreeing on common targets, testing and counselling services and mobilizing the public and communities.
- There is uncertainty about how to avoid antiretroviral therapy becoming a stand-alone programme and how to ensure that it leads to overall strengthening of health systems and a continuum of care: for example, in countries with high rates of TB and HIV coinfection, further collaboration with TB control programmes is desirable (Box 5).

WHO will: ensure that scaling up makes use of existing infrastructure and delivery mechanisms (especially TB, general medical and antenatal); promote referral models between primary, secondary and tertiary care; integrate HIV/AIDS training into overall human resource strategy; and promote policy collaboration between HIV/AIDS, development partners and health systems specialists.

Box 5. HIV and TB: two diseases, one person

Over the past 50 years, TB workers have developed a delivery system for the drug management of TB that is now sufficiently robust to reach into many low-income, low-infrastructure settings. Known as DOTS (directly observed therapy, short course), it also includes a simple diagnostic process, supervised treatment – at least in the initial phase – and recording and reporting the outcome of each case. Each year 3 million cases are treated using the DOTS approach.

TB is such a major killer of people with HIV/AIDS that TB needs to be seen as more than just another opportunistic infection and more than just an entry point. Delivery of TB treatment offers many lessons and potential synergy with efforts to scale up access to antiretroviral therapy. The same person often has TB and needs HIV treatment. Existing TB delivery services offer ready opportunities for both treating and preventing HIV. Similarly, emerging delivery services for antiretroviral therapy need to identify people with TB and refer them for sputum testing.

Most TB work is done by general health workers in general health services. The same applies to HIV/AIDS. Significant resources can be saved by ensuring that training for health workers, supervision of smaller health facilities by district hospitals and monitoring and evaluation address both diseases.

The fixed-dose combination drugs required for both TB and HIV come from similar, if not always identical, pharmaceutical companies and are intended for the same people. Procurement, purchasing and supply chain management of drugs for both conditions can be streamlined in many cases.

The diseases, however, are clinically different and require different technical approaches and different treatments. Each country needs a central unit of experienced professionals responsible for ensuring that a universal standard of care is achieved for each disease, but the scaling up of antiretroviral therapy need not reinvent the wheel at every turn.

TB programme collaboration in scaling up antiretroviral therapy – the experience of Malawi

Malawi was one of the first countries to begin scaling up antiretroviral therapy nationally. The implementation of collaborative TB/HIV activities⁹ has progressed well, with 15 of 44 hospitals in 11 of 28 districts now providing routine HIV testing and counselling and cotrimoxazole preventive therapy for TB patients, with a plan to expand to the rest of Malawi by the end of 2005. Effective collaboration between TB and voluntary counselling and testing clinics has resulted in rates of acceptance of HIV testing among TB patients of over 70%. Lay counsellors function effectively along with nurse counsellors in the hospital, compensating for an acute shortage of nurse counsellors.

⁹ Collaborative TB/HIV activities in Malawi build on the foundations of the ProTEST project of WHO and partners, which showed how district-level TB and HIV collaboration could work and the benefits that could be derived. They are supported by the United Kingdom Department for International Development, the KNCV Tuberculosis Foundation, the Norwegian Agency for Development Cooperation and WHO. For more information, see Interim policy on collaborative TB/HIV activities (http://www.who.int/hiv/pub/prev_care/tbhiv/en, accessed 25 June 2004).

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Beginning this year, collaboration between TB and voluntary counselling and testing clinics will be further enhanced through the use of a standardized voluntary counselling and testing register. The HIV/AIDS unit in the Ministry of Health developed the register in collaboration with other stakeholders, including the national TB programme. All clients accessing voluntary counselling and testing will be asked whether they have been referred from care services, including TB. After post-test counselling, clients who admit having a cough for more than three weeks will be referred to TB services. All these will be documented in the voluntary counselling and testing register, making it easy to capture data about how many people with TB are accessing voluntary HIV counselling and testing and how many people accessing voluntary HIV counselling and testing are subsequently referred to TB services.

The HIV Unit of Malawi's Ministry of Health, working within the Department of Clinical Services, designed the Malawi plan for scaling up antiretroviral therapy and took it forward after a wide consultative process that included the national TB programme as one of the key stakeholders.

This 2-year (2004–2005) plan includes rapidly scaling up antiretroviral therapy nationwide that builds on many of the components of the DOTS strategy and the experience of the national TB programme in implementing collaborative TB/HIV activities. The goal of the plan is to provide antiretroviral therapy for 80 000 eligible people by the end of 2005, which exceeds the expected "3 by 5" target (65 000). Further, the plan foresees collaboration with the national TB programme at all levels to develop the systems and modalities for supervising, monitoring and evaluating the delivery of antiretroviral therapy.

National guidelines – both for the use of antiretroviral therapy and for the management of HIV-related diseases – have been developed, along with a curriculum to train health workers in antiretroviral therapy and in managing HIV-related opportunistic infections. These guidelines and curriculum include a) the eligibility of people living with HIV/AIDS for antiretroviral therapy, b) intensified TB case detection, rapid investigation and early treatment of diagnosed TB and c) TB preventive therapy for people living with HIV/AIDS among whom active TB has been excluded.

Collaboration between the national TB and HIV/AIDS programmes will be further strengthened with the agreement that the TB programme will use its existing regional staff and infrastructure to monitor antiretroviral therapy services in Malawi.

Antiretroviral roll-out begins in September 2004 in close collaboration with the national TB programme and as an integral component of collaborative TB/HIV activities. Nationwide coverage is expected within two years, making Malawi a leader in delivering antiretroviral therapy in Africa.

2.4.3 Country-level gathering of information and data

WHO is uniquely placed at the global and regional levels to collect, monitor, synthesize and report on relevant country-level intelligence in the scaling up of HIV/AIDS treatment and care. A system to routinely collect information related to the status of HIV/AIDS treatment and care has been established and will be used to analyse information and provide advice and guidance to WHO staff, country counterparts and other partners.

Key data sources and collection methods

Multiple data collection methods and data sources will be used to ensure the greatest efficiency and relevance of country intelligence-gathering. These include existing data sources, country missions and deployments, country surveys and the "3 by 5" Incident Room and Help Desk.

Existing data sources. Sources of data include country assessment reports and research articles, key country strategy documents, country and partner surveys, consultations in-house and with partners, proposals and work plans of the Global Fund to Fight AIDS, Tuberculosis and Malaria, World Bank assessment and project documents and documents from UNAIDS Cosponsors, major bilateral partners and donors and nongovernmental organization initiatives.

Country missions and deployments. WHO staff and consultants have been deployed to a number of countries for scoping missions and longer-term periods to provide direct technical assistance for country scale-up. A structured checklist has been used to guide intelligence-gathering on these missions and deployments. “3 by 5” country teams use a template for regular reporting on progress in implementing antiretroviral therapy.

Country surveys. Where necessary, surveys and other data collection instruments are used to gather specific data from countries related to scaling up antiretroviral therapy. For example, regular surveys of progress toward reaching the “3 by 5” target have been designed to gather country information for reporting on the “3 by 5” milestones. The resulting database includes: key information on progress from each country; capacity development situation and needs (including human resources and training); and HIV testing and counselling services.

“3 by 5” Incident Room and Help Desk. The “3 by 5” Incident Room is one of the key contact points in WHO headquarters for regular “3 by 5” communication with countries and regional offices, including deployed WHO staff, “3 by 5” country teams and partners. It facilitates communication between country and regional staff and headquarters counterparts. The “3 by 5” Incident Room manages all country support databases and provides country progress reports. Based in the “3 by 5” Incident Room, “3 by 5” Help Desk staff and country support analysts track incoming country information on scaling up antiretroviral therapy and provide a rapid response to all country requests, questions and issues requiring immediate resolution.

Major products

Major products include a “3 by 5” Country Support Database and country profiles for HIV/AIDS treatment scale-up.

The “3 by 5” Country Support Database collects and makes available relevant global and regional information and information for each focus country. The database synthesizes data obtained by reviewing existing materials, country missions and deployments, country surveys and information collected by the “3 by 5” Incident Room.

Detailed country profiles for HIV/AIDS treatment scale-up are developed for all focus countries participating in scaling up. These profiles are updated regularly as new information is made available. The profiles are developed jointly with the respective national government counterparts and partners in each country. The data are drawn from the “3 by 5” Country Support Database. For each country the profiles include information on basic demographic and HIV/AIDS indicators; situation analysis; country policies, structures and programmes for HIV/AIDS treatment; data on antiretroviral therapy coverage; resource requirements and funds committed for scaling up antiretroviral therapy; the role of various implementation partners involved in scaling up antiretroviral therapy; progress in implementing the “three ones” principles; and information on WHO support in the country so far and priorities for further WHO support. The profile aims to be a practical tool to help guide countries in their scaling-up efforts, to monitor progress and to clarify roles and responsibilities across different partners. The profiles are targeted for in-country use and can be made available from WHO to interested parties on request.

Based on the full country profiles, summary country profiles are produced for public distribution. These single-sheet profiles are updated regularly to ensure that they provide current and relevant information on the situation of scaling up antiretroviral therapy in “3 by 5” focus countries.

2.5 Scaling up care and support

Antiretroviral therapy can only be effective if provided as part of a continuum of HIV/AIDS care and support interventions and services that address the broad range of needs of people living with HIV/AIDS, including those that are not purely biomedical. Comprehensive care and support require a multidisciplinary and multisectoral approach involving many different community elements for effective delivery. This requires developing innovative partnerships with existing services and structures and, in some cases, developing new systems and processes to ensure the adequate and sustained delivery of comprehensive care and support.

This section describes several of the key elements of that continuum and the contribution WHO will make to scaling them up in parallel with the expansion of antiretroviral therapy.

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2.5.1 Home and community-based care

Chronic care over the course of a lifetime is best provided as close as possible to where people live. For people living far from treatment and care facilities who do not have access to transport or whose mobility is otherwise restricted, providing care in the home and community is critically important.

This requires community organization and support. Capacity-building, including training of home-based care providers – such as nurses, community health workers, other people living with HIV/AIDS, friends and family members – is required to ensure that services are adequately delivered and used and that the quality of care is maintained. However, shifting work to communities has to be synchronized with shifting of resources to communities and requires investment in systems of monitoring and support for community-based treatment supporters and care providers.

WHO will: develop policy and strategies for incorporating home-based care into overall national health systems; develop core training competencies and curricula for community health workers and treatment supporters; and endorse national guidelines for home care services, including basic palliative care by family members and community volunteers.

2.5.2 Palliative care

Palliative care includes the management of physical symptoms such as pain, cough, skin rashes, fever and diarrhoea as well as dealing with psychosocial elements of disease, including depression, suicidal thoughts and other mental health problems. It also comprises spiritual support and bereavement counselling and is inclusive of the client and his or her environment. Palliative care often requires a multidisciplinary approach.

WHO will: develop a policy statement on palliative care in HIV/AIDS; develop guidelines on HIV/AIDS and palliative care and advocate for including palliative care in national scale-up plans and HIV/AIDS guidelines in hospital, clinical, community-based and home settings; incorporate palliative care in HIV/AIDS training materials and approaches (based on the WHO Integrated Management of Adult and Adolescent Illness approach and other appropriate standards); support the inclusion of palliative care in curricula for health care providers; and develop policy on morphine use and availability, including who will be permitted to administer narcotics.

2.5.3 Nutritional support

Nutrition plays an important role in maintaining immune function. Good nutrition increases resistance to infection and disease, improves energy, maintains strength and enhances productivity. People with HIV/AIDS are more at risk for malnutrition for reasons such as reduced food intake, poor absorption, changes in metabolism, chronic infections and illnesses, anorexia, diarrhoea, fever, nausea, oral and oesophageal infections and anaemia. Managing these conditions and providing nutritional support are effective interventions that are fundamental to other HIV/AIDS care activities. Antiretroviral drugs should often be taken together with food, making access to adequate food important to effective treatment.

WHO will: integrate nutritional support into policy and technical guidance on treatment and care; assess related education and training needs; identify partners to determine the need for and to provide direct food assistance; and incorporate nutrition into policy and technical guidance on home-based care programmes.

2.5.4 Psychosocial support

Psychosocial support is important to everyone with chronic disease, including people living with HIV/AIDS. Counselling, spiritual support, support to enable disclosure, risk reduction and adherence to treatment, are all important at different stages of disease progression and the continuum of care, including the end of life. In addition, mental health issues have long been neglected in policies and guidance on HIV/AIDS care and must be addressed to ensure appropriate care and support for people living with HIV/AIDS and their families.

WHO will: integrate psychosocial support into policy and technical guidance on treatment and care,

including the special needs of vulnerable populations; advocate including psychosocial support in national scale-up plans, training initiatives, curricula and HIV/AIDS guidelines in hospital, clinical, community-based and home settings; map mental health services and identify gaps; and hold a consensus meeting on the mental health needs of people living with HIV/AIDS in resource-limited settings to identify programme priorities and operations research needs.

2.6 Accelerating prevention

2.6.1 Overview

Prevention remains central to a comprehensive public health response to HIV/AIDS. To reduce the growth and size of HIV epidemics at a population level, prevention efforts must intervene effectively in low-prevalence settings and in situations where the potential for transmission is greatest, and they must reach sufficient scale. WHO's interventions in prevention focus on these key areas:

- testing and counselling as the entry point to both treatment and prevention;
- comprehensive programmes to prevent HIV infection among women, infants and young children; and
- targeted interventions for vulnerable populations, including injecting drug users, sex workers, young people and people living with HIV/AIDS.

Similar to scaling up antiretroviral therapy, WHO's specific contribution in these areas of prevention work includes normative, technical and operational guidelines, capacity-building and technical support to countries. This contribution will be provided through broad technical partnerships.

WHO is especially concerned with reducing HIV infection in women, who are increasingly vulnerable to HIV infection. Renewed efforts are required to develop and expand effective interventions that alter the factors at the individual, household and community levels that determine women's vulnerability to HIV infection. These factors include mobility, poverty, violence, the social constructions of masculinity, HIV risk behaviour among men and biological characteristics.

Increased access to antiretroviral therapy creates new opportunities for accelerating prevention. Some benefit may derive directly from the provision of treatment, such as the biological effects of treatment that may influence infectiousness. Other opportunities for accelerating prevention will result from enhanced health care access related to the scaling up of antiretroviral therapy, such as improved access to the diagnosis and treatment of sexually transmitted infections. More broadly, the wider availability of treatment will result in a fundamental shift in public health and societal perceptions and responses to the epidemic. In most settings where treatment has been made available, this has resulted in a large-scale increase in the number of people who know their HIV status and receive counselling and has increased community awareness about HIV/AIDS. However, treatment can potentially dilute prevention efforts. A concerted effort must therefore be made to target interventions where risk remains high, such as among young people, and to link prevention with treatment along a continuum of services.

2.6.2 Testing and counselling

Recent studies indicate that overall coverage of testing and counselling is extremely poor in countries with the highest HIV burden. Worldwide, only 5% of people with HIV are estimated to be aware of their status. Dramatically scaling up access to testing and counselling is therefore key for successfully implementing antiretroviral therapy. HIV status must be known before treatment can commence or before decisions can be taken about future prevention needs, such as in preventing mother-to-child transmission. WHO advocates offering HIV testing and counselling widely in health care settings to everyone who might benefit from knowing their HIV status. Knowing one's status enables people to initiate or maintain behaviour to prevent the acquisition or further transmission of HIV.

WHO will: map and report on the coverage of testing and counselling in high-priority countries; publish core curricula for training the counselling and support staff at sites where testing and counselling are offered; publish standard operating procedures for integrating testing and counselling into clinical care sites, including in- and outpatient, TB, sexually transmitted infections, antenatal and family planning services and services targeting injecting drug users and sex workers; provide technical assistance to strengthen testing

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and counselling capacity at the country level; develop and publish indicators of testing and counselling quality to be applied at the programme level; develop and publish training curricula for the use of rapid HIV tests; develop communication campaigns aimed at lowering stigma, normalizing HIV testing and learning one's HIV status; support operations research to assess the optimal integration of testing and counselling into clinics; and develop operational protocols for psychosocial care and support of people living with HIV/AIDS in resource-constrained settings.

2.6.3 HIV prevention and care for women and children

Of the estimated 4.1 million people 15–49 years old who became infected with HIV in 2003, about half were women, and this proportion is increasing. In addition, an estimated 630 000 children became newly infected with HIV, mostly associated with mother-to-child transmission.

It is important to make the most of existing opportunities to reach women with key HIV prevention and care interventions through existing reproductive and sexual health services, such as family planning, maternal and child health and care services for reproductive tract infections and sexually transmitted infections. To improve overall maternal and child health outcomes, services for preventing mother-to-child transmission must be comprehensive and integrated into reproductive, maternal and child health services. The HIV/AIDS and maternal and child health agendas have now converged, and programmes to prevent HIV among women, infants and children are seen as a rallying point for enhanced care for women and children and as an opportunity to strengthen related health systems.

WHO and its partners promote a comprehensive public health approach to preventing HIV infection among infants and young children consisting of four elements:

- primary prevention of HIV infection with a particular emphasis on reaching women of childbearing age and their partners with relevant services;
- prevention of unintended pregnancies among HIV-infected women;
- prevention of HIV transmission from HIV-infected women to their infants by providing specific interventions, including antiretroviral prophylaxis, safer delivery practices and infant feeding counselling and support; and
- the provision of treatment, care and support for women living with HIV/AIDS and their children and families.

WHO's area of work in research and programme development in reproductive health is also heavily engaged in prevention activities for women and children: in particular, research and development around linking reproductive health, preventing mother-to-child transmission, antiretroviral therapy and HIV prevention and providing technical guidance on interventions for the prevention and care of sexually transmitted infections.

WHO will: provide policy and technical guidance in implementing key interventions for preventing HIV transmission to women, infants and young children and for the care and support of those already infected or exposed as an integral component of essential services for reproductive and sexual health and for maternal and child health; provide operational guidance to strengthen links between preventing mother-to-child transmission and care, treatment and support services for HIV-infected women and their families; and provide, in partnership with other United Nations agencies and other key partners, technical support to countries for implementing and scaling up comprehensive and integrated prevention and care programmes for women and children and for building human capacity for preventing mother-to-child transmission and for related treatment, care and support.

2.6.4 Community-based interventions

Poverty, gender inequality, population displacement and instability are important structural factors that increase vulnerability to HIV infection, especially for women. Stigma and fear of HIV/AIDS are widespread. A range of strategies for communication and service delivery are needed at the community level to help to create more enabling environments for prevention, in addition to removing barriers that keep people from accessing HIV testing and counselling, prevention and treatment services.

Young people (10–24 years) remain at the centre of the HIV/AIDS pandemic in terms of transmission, impact and potential for change. Over 2 million young people continue to become infected with HIV every year. WHO has a specific mandate for health-sector interventions, which includes support for the prevention of HIV among young people, as well as treatment and care. WHO's Department of HIV/AIDS focuses on the most vulnerable categories of young people: young women and men in sex work, young people who use drugs and HIV orphans. WHO's Department of Child and Adolescent Health and Development is also engaged in prevention and reducing vulnerability among young people, including developing training materials and programmes in focus countries, operations research and programme guidance on strategic information and supportive evidence-based policies.

WHO will: support and coordinate prevention activities targeted at young people within WHO and with the United Nations Population Fund, UNAIDS and other United Nations partners; develop guidance and tools for health ministries to include young people in prevention activities; and develop capacity and provide technical support to countries for early implementation and scale-up of rapid assessment responses and other interventions targeting young people.

2.6.5 Programme communication

Information and education about HIV/AIDS, especially for vulnerable populations, including women, is an essential component of prevention as well as interventions to scale up testing and counselling and treatment. WHO supports an integrated approach to communication emphasizing combating stigma through community-based programming. This includes leading and supporting communication campaigns for normalizing testing and counselling. In particular, WHO is focused on working with partners as implementers of strategic communication work at the country level.

WHO will: develop a network of communication specialists to share experiences and best practice; provide technical support to countries for developing communication strategies with a focus on participatory methods; develop and publish technical guidelines on the effective integration of communication related to prevention and treatment; undertake capacity-building programmes in regions and countries; and support treatment awareness within communities.

2.6.6 Targeted interventions for vulnerable populations

Injecting drug users

Injecting drug use is driving the most rapidly growing HIV/AIDS epidemics in the world. About 10% of new HIV infections worldwide – and as high as 80% in some countries – are attributable to injecting drug use. HIV can spread rapidly in injecting drug-using populations and then stabilize at very high levels. For example, HIV infection among injecting drug users in Ukraine rose from virtually zero in 1994 to 31–57% in less than two years.

In many countries, injecting drug users have limited access to HIV/AIDS prevention and care services. Users of illicit drugs are often marginalized and threatened by sanctions if they seek institutional treatment and other services. However, criminalizing drug use can increase rather than reduce the spread of HIV by forcing injecting drug users underground and thereby further reducing their access to services.

To combat the spread of HIV among injecting drug users and their sex and drug use partners, WHO supports harm reduction activities, beginning with peer-based outreach. Rather than waiting for injecting drug users to enter health institutions, more services need to be provided in places where drug users are and where they use drugs.

Successful efforts to reduce drug-related harm – including crime and other health conditions in addition to HIV/AIDS – build on three main complementary strategies:

- supporting drug users who are ready to stop using drugs: for example, through drug treatment services, including drug substitution treatment such as methadone for heroin users;
- reducing injecting among those who continue using drugs: for example, through communication and counselling programmes that provide information on ways to prevent or minimize the risk of HIV infection; and
- reducing the sharing of injection equipment among injecting drug users: for example, by providing sterile injecting equipment in needle and syringe programmes.

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Comprehensive HIV prevention and treatment activities for injecting drug users need to use innovative peer-driven approaches. Policies and legislation that support HIV prevention and treatment programmes for injecting drug users also need to be developed in many countries.

WHO will: establish an evidence base for effective HIV/AIDS prevention and treatment among drug users; promote methods for rapid assessment and response among drug-using populations; provide technical guidance and advocacy on scaling up outreach to injecting drug users; provide technical support and guidance on peer interventions; support harm reduction and promote access to drug dependence treatment programmes and to antiretroviral therapy; and mobilize harm reduction networks to implement effective HIV/AIDS prevention and treatment interventions.

Sex work

More than 80% of new HIV infections occurs through heterosexual contact. Factors that increase the rate and efficiency of heterosexual HIV transmission include high rates of changing sex partners and the presence of other sexually transmitted infections. Both these factors can be addressed through proven interventions – peer outreach, condom programmes and efforts to control sexually transmitted infections – that focus on networks of sex workers.

WHO will: provide technical guidance and programme support to countries on how to scale up prevention interventions for male and female sex workers and their clients, including screening and treatment and care services for sexually transmitted infections.

Other especially vulnerable populations

Migrant and refugee populations, seasonal workers, men who have sex with men and incarcerated people in closed settings are especially vulnerable and need specific prevention interventions. Especially vulnerable populations are often difficult to reach.

WHO will: synthesize an evidence base for effective HIV/AIDS prevention and treatment interventions among vulnerable populations; promote rapid assessment methods; support the mobilization of community-based organizations reaching out to such groups; and provide policy guidance. WHO will work in close collaboration with appropriate lead agencies, such as the Office of the United Nations High Commissioner for Refugees and the International Organization for Migration, as well as with national authorities, including justice ministries, to promote interventions for these groups.

2.6.7 Safer clinical settings

Interventions promoted by WHO include injection and blood safety measures as well as policies, supplies and training to eliminate transmission in health care settings. In addition, postexposure prophylaxis must be available in case of accidental exposure. Particular emphasis must be focused on facilities in high-transmission areas.

WHO will: carry out situation analyses and mapping; develop technical guidelines and training curricula; monitor and evaluate programmes; and provide technical support for the planning and evaluation of national programmes.

2.6.8 Prevention for people living with HIV/AIDS

People living with HIV/AIDS are a logical but neglected focus for prevention programmes. Effective prevention interventions among people living with HIV/AIDS can significantly affect the spread of the epidemic (Box 6). Providing knowledge and skills related to prevention helps to reduce transmission to uninfected partners. Experience indicates that people receiving treatment will take steps to adopt safer behaviour if they understand the issues and are supported with ongoing counselling. WHO therefore supports an integrated approach that strengthens prevention interventions linked to treatment services. Clinic-based prevention services should be reinforced and integrated into the regular schedule of consultations.

WHO will: provide technical guidance and programme support to enable a full package of interventions to prevent HIV infection, including sexual and reproductive health counselling and support; promote education and risk-reduction counselling for people living with HIV/AIDS; promote beneficial disclosure and partner referral for testing and counselling; and promote education on and supply of condoms, harm reduction services, treatment of sexually transmitted infections and counselling for couples to reduce the risk of transmission between partners.

Box 6. The essential package of care and prevention services necessary to support antiretroviral therapy

In November 2003, in Lusaka, Zambia, WHO and UNAIDS hosted an International Consensus Meeting on Technical and Operational Recommendations for Emergency Scaling-Up of Antiretroviral Therapy in Resource-Limited Settings. This meeting brought together more than 100 experts, including people living with HIV/AIDS, treatment advocates, United Nations agencies, policy-makers, donors and nongovernmental organizations involved in providing HIV/AIDS treatment, care and support.

Meeting participants acknowledged that scaling up antiretroviral therapy needs to form part of a continuum of services and that many services currently provided solely at the central and district level need to be quickly expanded to health centres and, for many of the routine elements of patient management, into community settings in which expertise already exists and can be rapidly built upon with appropriate resources and training.

The meeting resulted in a number of consensus recommendations for rapidly scaling up antiretroviral therapy at various levels of the health system in the following categories:

- people living with HIV/AIDS and communities as leaders in antiretroviral therapy;
- the essential package of care and prevention services necessary to support antiretroviral therapy;
- service delivery, human resources and training;
- management of commodities and supplies; and
- strategic information.

The meeting participants made the following recommendations on the essential package of care and prevention services necessary to support antiretroviral therapy.

Recommendation 1A. Antiretroviral therapy should be initiated in facilities at all levels of the formal health care system as soon as the following minimum conditions are available:

- HIV testing and counselling;
- personnel trained and certified to prescribe antiretroviral therapy and follow up recipients clinically;
- an uninterrupted supply of antiretroviral drugs; and
- a secure and confidential patient record system.

Recommendation 1B. The following must be made available at all levels of the health system concurrent with (and following) the introduction of antiretroviral therapy:

- adherence support; and
- community mobilization and education on antiretroviral therapy.

Recommendation 2. People with symptomatic WHO Stage III and IV conditions who have tested HIV-positive and received post-test counselling should be offered antiretroviral therapy immediately.

Recommendation 3. Stavudine + lamivudine + nevirapine should be the preferred first-line regimen for the immediate implementation of large-scale antiretroviral therapy programmes in resource-limited

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settings. Fixed dose combinations should be used as soon as formulations of proven quality and bioequivalence are available and provide programmatic advantages.¹⁰

Recommendation 4. Chronic HIV/AIDS care capacity should be developed in health facilities concurrently with – and not as a prerequisite for – the introduction of antiretroviral therapy.

Recommendation 5. Laboratory tests should be used according to the 2003 WHO treatment guidelines.¹¹

Recommendation 6. HIV testing and counselling should be available in health-sector facilities at all levels of the health system and should be included in the service package of programmes that target vulnerable and difficult-to-reach populations.

Recommendation 7. Simple, rapid, finger-prick tests should be the tests of choice in scaling up testing and counselling services.

Recommendation 8. Strengthen existing HIV prevention services while antiretroviral therapy is being introduced. [This includes scaling up of outreach to vulnerable populations with a particular focus on poor people, sex workers, men who have sex with men and injecting drug users. Services should emphasize HIV testing and counselling, treatment of sexually transmitted infections, promotion of safer sex, condom distribution and harm reduction services.]

Recommendation 9. Ensure that people living with HIV/AIDS receive key prevention services and commodities.

Source: adapted from *Emergency scale-up of antiretroviral therapy in resource-limited settings: technical and operational recommendations to achieve 3 by 5*. Report of a WHO consultation. Geneva, World Health Organization, 2003 (<http://www.who.int/3by5/publications/documents/zambia/en>, accessed 25 June 2004).

¹⁰ Following the Lusaka meeting, on 1 December 2003, WHO prequalified the first triple fixed-dose combinations of the above preferred first-line regimen. WHO-prequalified products are listed at <http://mednet3.who.int/prequal> (accessed 25 June 2004).

¹¹ Scaling up antiretroviral therapy in resource-limited settings: treatment guidelines for a public health approach – 2003 revision. Geneva, World Health Organization, 2003 (http://www.who.int/3by5/publications/documents/arv_guidelines/en, accessed 25 June 2004).

3. Structure of WHO and model for service delivery

3.1 Structure

3.1.1 Overview

WHO is structured to provide a mechanism by which international knowledge can be translated into good practice in health at the global, regional and country levels. The roles of the three different levels of WHO in supporting the response to HIV/AIDS are described below. In addition to clarifying and reinforcing the respective roles of each level of the Organization, WHO is committed to allocating the majority of its spending to the regional and country office levels. In 2002–2003, 66% of total WHO spending on HIV/AIDS occurred at the regional and country levels. As Fig. 1 shows, WHO aims to spend 87% of its HIV/AIDS budget in the 2004–2005 biennium at the regional and country levels. Section 5 covers financial and staffing details.

Fig. 1. WHO HIV/AIDS Budget Allocation 2004–2005

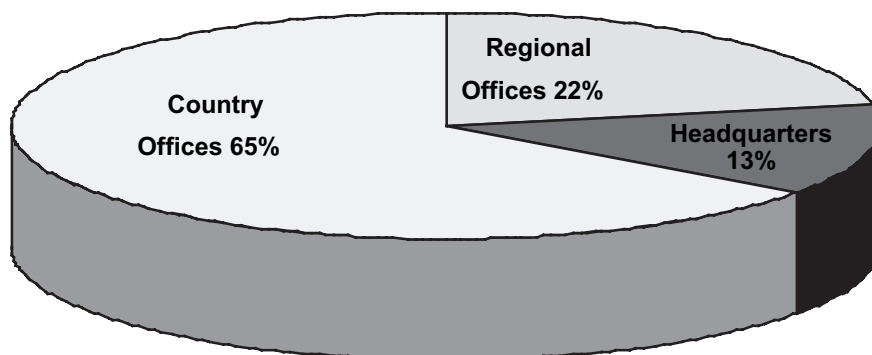


Fig. 2 shows how the various levels of WHO are linked together to deliver HIV/AIDS services to people living in WHO Member States in need of health services and to the governments of the Member States. Fig. 2 illustrates that people in need of health services are the most important concern. Within WHO, the inverted pyramid demonstrates how each level of the organization acts to assist and enable those above it in providing the required services to Member States and their citizens.

Fig. 2 The WHO model for service delivery



The following subsections briefly outline the scope of responsibility of each of the three levels of the WHO structure. As discussed in subsection 1.1, each country office, regional office and headquarters department is responsible for developing detailed work plans laying out the specific activities to be accomplished and describing the resource requirements and timelines based on the overall guidance provided by key organizational strategies and the WHO HIV/AIDS Plan. These work plans are integrated through joint planning sessions managed by programme management resources at regional offices and headquarters.

3.1.2 Country and liaison offices (65% of total WHO spending)

The country level of WHO is paramount, as the millions of people in need of HIV/AIDS services live at the country level. WHO country offices play a unique role in providing support and advice to health ministries and other health partners on a broad range of health issues. They also play an important convening and coordination role, bringing government and other partners together to develop and implement appropriate national responses to HIV/AIDS. The WHO representative or liaison officer coordinates WHO activities in the country. The WHO representative is considered the chief external or technical adviser to the government on health matters. WHO Country offices sometimes have dedicated staff working on general or specific programmes. These may be international staff or local staff employed as national programme officers. In the case of HIV/AIDS, WHO plans to staff the offices of focus countries with one “3 by 5” HIV/AIDS country officer who, in conjunction with the WHO representative or liaison officer and working closely with all other partners acting at the country level, will plan WHO’s overall response in the country. The country officer will be supported by an appropriate number of additional resources, including a substantial activity budget plus other international staff, national programme officers and administrative staff.

These teams are expected to be largely established by the fourth quarter of 2004. They will work with the national AIDS coordinating body and other partners to develop a comprehensive response in each country. Although WHO is prepared to provide a wide range of support at the country level if requested, subsection 2.2 describes the areas in which WHO feels it is best equipped to add value.

This shifting of incremental resources in the HIV/AIDS area of work to the country level is closely aligned with the WHO decentralization policy and process underway that strives to strengthen WHO country offices through the WHO country cooperation strategy in each country (Box 7). The enhanced performance of WHO country offices should ensure better technical support for countries in developing integrated responses to HIV/AIDS and more effective participation by stakeholders, including people living with HIV/AIDS, nongovernmental organizations and other civil society groups.

Box 7. The WHO country cooperation strategy

The WHO country cooperation strategy uses a process through which WHO reflects and defines its strategic vision for the medium term in a specific country. The process emphasizes consultation and strategic dialogue with stakeholders at the country level and inside WHO. It is led by the WHO representative, and most of the responsibility for the process lies with the country office, with inputs from the regional office and WHO headquarters.

The timing and justification for formulating a country cooperation strategy depend on the country context. In the context of “3 by 5”, specific country cooperation strategies will be updated to include the new efforts to increase access to antiretroviral therapy.

WHO’s work to scale up antiretroviral therapy needs to take place through existing national processes and coordination mechanisms to ensure that the scaling-up effort forms part of national policies and programmes. The country cooperation strategy therefore provides a framework for examining critical challenges facing health systems at the country level.

The country cooperation strategy also relates to other processes in the country: the national poverty reduction strategy paper, sector-wide approaches and others, and activities led by the Common Country Assessment/United Nations Development Assistance Framework as well as activities led by other agencies. It also allows WHO to examine how it can work better as part of the United Nations country team and overall health development partners.

The country cooperation strategy also provides a framework for the country level to determine workforce

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needs to realize the work plan of the country office.

3.1.3 Regional offices (22% of total WHO spending)

The overall responsibility of each of the six WHO regional offices is to support the countries in its region. The regional offices do this in a variety of ways, including:

- translating global norms, standards and knowledge into regional contexts;
- developing technical standards unique to the region;
- building the competencies and capacities of country offices;
- providing financial and human resources support to country offices;
- providing the first level of response to country requests for technical assistance;
- identifying areas in which headquarters support is required and coordinating the provision of such assistance; and
- coordinating and integrating individual country needs into an overall regional programme budget for HIV/AIDS.

While there are variations in the way Regional Offices are structured and how the Regional HIV/AIDS Programmes are positioned in each Office, in all cases HIV/AIDS work at Regional Offices is coordinated by Regional Advisors (RA) for HIV/AIDS. These Advisors provide a critical linkage in both directions with HIV/AIDS staff at country and headquarters level. They also coordinate HIV/AIDS activities with other programmes at the Region Office level.

Similar to country offices, WHO is also strengthening the HIV/AIDS presence at the regional office level. Regional offices will be equipped with appropriate numbers of staff and activity budgets to enable them to provide the necessary support to countries effectively and efficiently (see Section 5).

3.1.4 Headquarters (13% of total WHO spending)

Staff of the Department of HIV/AIDS at WHO headquarters perform two main functions.

They support WHO regional and country offices in the effective delivery of HIV/AIDS health services at the country level. This is largely accomplished by working closely with colleagues in regional and country offices and providing technical support in a variety of ways, including missions to countries to address specific needs.

They also take leadership in a variety of areas, including overall advocacy and policy for HIV/AIDS issues, broad-based HIV/AIDS research, development of technical norms and standards and collaborating with other technical departments performing HIV/AIDS work in their respective fields of health. Examples of this collaboration between the Department of HIV/AIDS and other departments include:

- the Interim Policy on Collaborative TB/HIV Activities (with Stop TB/Partnership Secretariat);
- guidance on ethical and equitable access to antiretroviral therapy (with Ethics, Trade, Human Rights and Health Law);
- health systems policy, including financial analysis and human resource needs for scaling up antiretroviral therapy (with Evidence and Information for Policy and Strategic Planning and Innovation);
- drug prequalification and essential medicines (with Essential Drugs and Medicines Policy);
- links between HIV/AIDS and sexual and reproductive health (with Reproductive Health and Research) and HIV/AIDS prevention for young people (with Child and Adolescent Health and Development);
- analysis of opportunities and constraints to health systems posed by scaling up efforts (with Strategic Planning and Innovation); and
- development of an operations research and knowledge management agenda (with the Special Programme for Research and Training in Tropical Diseases).

The Department of HIV/AIDS at WHO headquarters manages several interdepartmental working groups that assemble staff from across the Organization to focus on specific activities and expected results. Similarly, the Assistant Director-General for HIV/AIDS, Tuberculosis and Malaria chairs an Organization-wide task force composed of all Assistant Directors-General to enhance communication and coordination, identify

and solve problems and provide high-level political commitment to HIV/AIDS work.

3.2 Matching support with country needs

The set of services, activities and anticipated results WHO offers varies from country to country, depending on the level of action (country, regional or global), the other partners involved and the ability of WHO to respond (Table 3). The following principles underlie the WHO response:

- WHO will focus its efforts and resources in countries where positive impact is anticipated to be greatest.
- WHO will provide different levels of support to different countries according to need.
- WHO will focus on a specific number of technical areas in which it has comparative advantage and the greatest impact can be achieved.
- WHO will work closely with partners and build on already existing and planned initiatives.

More effective mapping of country-level activity through real-time information networks and a regular country profiling process will enable more accurate assessment of both the needs of specific countries and the capacity of WHO and other partners to respond.

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Table 3. Types of technical support WHO provides

Type of technical support WHO provides	Provided to
<p>Responsive technical support WHO provides responsive technical support according to the requests and identified needs of all Member States. Primary responsibility for technical support rests with the WHO country office, with support from the regional office. The Department of HIV/AIDS at WHO headquarters provides support by:</p> <ul style="list-style-type: none"> • ensuring that WHO country and liaison offices possess the core competencies required to respond to country requests, either by providing direct technical assistance or by referring to other WHO units or other agencies; • enabling Member States to readily access strategic, policy and normative information and key tools and guidelines; • strengthening regional technical networks and institutions that can act as resources for countries in implementing national programmes; and • providing direct technical assistance to Member States where specific needs have been identified or crisis situations emerge. 	All Member States
<p>Proactive technical support WHO provides proactive technical support to “3 by 5” focus countries, which have the greatest HIV/AIDS treatment needs or have been identified as regionally strategic. Support involves a partnership across WHO headquarters, regional offices and country offices. In addition to the support described above for all Member States, technical support focuses specifically on scaling up antiretroviral therapy, including:</p> <ul style="list-style-type: none"> • strengthening WHO country offices with dedicated HIV/AIDS teams and health systems specialists; • providing direct technical support in developing and implementing national HIV/AIDS health-sector plans, with a specific component of treatment and care, including antiretroviral therapy; • integrating WHO tools and guidelines into national institutions and programmes; • supporting national strategic capacity-building; • strengthening key national HIV/AIDS institutions, health systems and resource centres, especially clinical services, laboratory facilities, drug procurement and management systems, testing and counselling, monitoring and evaluation, human resource development and referral systems; • facilitating the establishment of partnerships at the national and district levels and coordinating with other major initiatives, especially those focusing on scaling up antiretroviral therapy; • ensuring the technical soundness of interventions; • guiding the development of an operations research agenda addressing key questions relevant to programmatic areas and health systems development; • helping to document experience and disseminate tools that would inform other countries; • assisting in mobilizing and managing resources; and • supporting countries in designing scale-up plans that are ethically sound and equitable. <p>Several countries (such as China, Ethiopia, India, Nigeria, the Russia Federation and South Africa) play a pivotal role in determining the future of the HIV/AIDS pandemic. These are countries with large populations and/or geographical size where the current or potential spread of HIV/AIDS will have major regional or global impact. In addition to the assistance described above, incremental decentralized support will be provided.</p>	“3 by 5” focus countries (Annex 1)

4. Implementation through partnership: working together to make it happen

WHO is only one of many organizations working to scale up antiretroviral therapy, accelerate prevention and contribute to the overall response to HIV/AIDS. The focus of much work is at the country level, where people live, where HIV is transmitted and where treatment must be offered. Partners involved in the global response include United Nations and multilateral agencies, foundations, nongovernmental, faith-based and community organizations, the private sector and labour unions and, importantly, representatives of the community of people living with HIV/AIDS. To achieve the “3 by 5” target, the Millennium Development Goals and the goals of the Declaration of Commitment on HIV/AIDS, every individual and organization must play their part. Activities across the WHO HIV/AIDS programme are undertaken in concert with a variety of stakeholder-specific working groups and technical collaborations, including the “3 by 5” Global Partners Group, United Nations system partners, technical partnerships, country-level partners, donors and civil society, faith-based and private-sector groups.

4.1 The “3 by 5” Global Partners Group

The “3 by 5” Global Partners Group comprises a wide range of major international organizations encompassing all stakeholder groups. The purpose of the “3 by 5” Global Partners Group is to ensure regular opportunities for information exchange and advocacy between stakeholders in the global movement to scale up the response to HIV/AIDS.

4.2 United Nations system partners

The UNAIDS family of organizations has committed its full support to scaling up treatment and accelerating prevention. In addition to WHO, several provide support to health ministries:

- the United Nations Population Fund for links between reproductive health services and HIV;
- UNICEF for its focus on mother-to-child transmission of HIV, adolescent and child welfare and procurement of antiretroviral drugs and treatments for opportunistic infections;
- the United Nations Development Programme for its focus on involving people living with HIV in developing policy and designing programmes;
- the International Labour Organization for workplace health policy; and
- the World Bank as the largest donor of funds for health infrastructure development and planning.

Stronger relationships are also being developed with the newest UNAIDS cosponsors, the World Food Programme, for food security and nutritional support as part of HIV/AIDS treatment and programmes for preventing the mother-to-child transmission of HIV, and the Office of the United Nations High Commissioner for Refugees, for HIV/AIDS interventions in emergencies, including among refugees and other displaced and emergency-affected populations.

The executive heads of the UNAIDS Cosponsors have agreed to the respective roles of these agencies in scaling up HIV/AIDS treatment and their contributions to realizing the “3 by 5” target. This is described in more detail in Annex 4.

The UNAIDS Secretariat and its UNAIDS country coordinators in country coordinate the multisectoral response on behalf of the United Nations system. This coordination is implemented through the United Nations country theme groups on HIV/AIDS, with the UNAIDS country coordinators acting as the secretariat at the country level.

Other examples include participation in interagency coordination mechanisms within the United Nations (for example, at the global level, WHO is the convening agency within the United Nations system for HIV/AIDS

treatment, care and support as well as for preventing the mother-to-child transmission of HIV) and involvement in other interagency mechanisms such as the Interagency Task Team on Injecting Drug Use convened by the United Nations Office on Drugs and Crime. Similar interagency coordination mechanisms exist at the regional and subregional levels.

4.3 Technical partnerships

WHO is heavily engaged in technical partnerships with other technical agencies, international nongovernmental organizations and community networks on specific issues. Examples include:

- cooperation with the Global AIDS Program of the United States Centers for Disease Control and Prevention and the United States Agency for International Development on HIV testing and counselling and activities for preventing the mother-to-child transmission of HIV and, in the WHO Western Pacific Region, work related to injecting drug users.
- partnership with Médecins Sans Frontières on various aspects of scaling up treatment and related capacity-building;
- working with the French project ESTHER (Ensemble pour une Solidarité Thérapeutique Hospitalière En Réseau) on capacity-building, training and strengthening the decentralization of services;
- collaboration with Family Health International, the AIDS Foundation East-West, the Open Society Institute and international and regional harm reduction networks on harm reduction and treatment access for injecting drug users;
- a partnership with UNAIDS, UNICEF, the World Bank and leading nongovernmental organizations involved in drug procurement to establish AMDS, aimed at supporting countries in strengthening their procurement of commodities and consistency in distribution systems;
- cooperating with training institutions and other stakeholders to establish standard competencies for a range of types of health worker, to ensure that training programmes related to antiretroviral therapy meet global norms;
- working with the Global Fund to Fight AIDS, Tuberculosis and Malaria to ensure that countries can develop fundable proposals and implement effective programmes to scale up antiretroviral therapy as part of a comprehensive approach to HIV/AIDS;
- cooperating with the All Africa Conference of Churches and Islamic medical associations (as a model for other faith-based organizations) to enhance existing pharmaceutical distribution networks for effective and reliable access to and distribution of pharmaceuticals and diagnostic supplies;
- collaboration with UNAIDS and the United States President's Emergency Plan for AIDS Relief to harmonize monitoring and evaluation indicators related to antiretroviral therapy;
- cooperation with the World Bank Treatment Acceleration Program (including nongovernmental organizations, associations and the private sector) on scaling up antiretroviral therapy; and
- working with the World Food Programme on information systems linking food insecurity and HIV/AIDS prevalence.

4.4 Country-level partners

Ultimately, treatment scale-up, improved prevention efforts and the implementation of a comprehensive response to AIDS require action by partners at the country level. WHO has worked and will continue to work with a wide array of partners to provide assistance and enable joint efforts.

At the country level, WHO's key traditional partner is the health ministry, the arm of government tasked with implementing health-sector activities for HIV/AIDS within the supportive strategic HIV/AIDS framework and as part of the overall national strategy.

WHO also contributes to strengthening mechanisms for partnership at the country level, including United Nations expanded theme groups on HIV/AIDS, country coordinating mechanisms and national AIDS commissions to ensure multi-stakeholder involvement and input to governments implementing antiretroviral therapy programmes.

Other traditional partners with which WHO will need to continue working include national and regional academic and research institutions in developing evidence-based, normative standards, guidelines and tools, either as WHO collaborative centres or as partners on specific projects.

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4.5 Donors

WHO works closely with a large number of bilateral partners that provide significant levels of technical and financial assistance to countries in mounting a comprehensive HIV/AIDS response. They include the Governments of Australia, Belgium, Canada, Denmark, France, Germany, Ireland, Italy, Japan, the Netherlands, Norway, Sweden, Switzerland, the United Kingdom, the United States of America and many others plus the European Union. Collaboration includes aligning their in-country support for activities with the technical and policy contributions of WHO to support country efforts. In addition to the development agencies of these countries, organizations providing technical assistance, private foundations and academic institutions are valued partners.

WHO also collaborates closely with the Global Fund to Fight AIDS, Tuberculosis and Malaria and the World Bank.

4.6 Civil society, faith-based and private-sector groups

Civil society, faith-based and private-sector groups have an important role to play in the response to HIV/AIDS. For example, with faith-based organizations performing up to 40% of AIDS care in Africa, fostering these relationships is critical to the success of “3 by 5”. Other partners in civil society include associations of people living with HIV/AIDS; business and occupational health service providers; labour organizations; and national and international nongovernmental organizations with longstanding experience in community mobilization, such as the International Federation of Red Cross and Red Crescent Societies and Planned Parenthood International. WHO has dedicated new resources and personnel to building relationships with these communities and organizations.

5. WHO programme budget and resource requirements

5.1 Overview of the programme budget

The 2004–2005 WHO programme budget as approved by the Executive Board in January 2004 identifies the budget requirements for the HIV/AIDS area of work for the biennium as US\$ 218.1 million.

The US\$ 218.1 million total represents a dramatic 269% increase in HIV/AIDS spending compared with the actual spending of US\$ 59 million during the 2002–2003 biennium.

In formulating this programme budget, WHO addressed three important questions.

- What is the appropriate geographical distribution of spending? How much of the budget should be allocated to country, region and headquarters activities?
- What proportion of investment should be made in treatment and care as part of a comprehensive response to HIV/AIDS and prevention, which continues to be the mainstay of the response?
- How should effort and funding be distributed across the functional areas of WHO's work?

5.1.1 Geographic distribution of funds and activities

WHO will dramatically increase the percentage of its budget spent at the country and region levels compared with headquarters activities. Specifically, the proportion of total spending at the country and regional levels will increase from 66% in 2002–2003 to 87% in 2004–2005. WHO will also ensure that funds are allocated in proportion to the geographical burden of disease. As a result, the African Region of WHO will receive 55% of total funds during the 2004–2005 biennium.

Table 4 vividly demonstrates the commitment WHO has made to significantly increase the proportion of its spending at the country and regional levels by showing the actual and projected spending over five bienniums.

Table 4. WHO spending on HIV/AIDS (in millions of US dollars), 1996–2005

Biennium	Budget or actual	Total WHO HIV/AIDS spending	Increase in spending compared with the previous biennium	Percentage spent at the headquarters level	Increase in headquarters' share of spending compared with the previous biennium
1996–1997	Actual	28	NA	24	NA
1998–1999	Actual	39	+39%	29	+21%
2000–2001	Actual	50	+28%	38	+31%
2002–2003	Actual	59	+18%	34	-11%
2004–2005	Budget	218	+269%	13	-62%

Table 5 provides further details of the budget according to WHO region.

Table 5. The 2004–2005 WHO HIV/AIDS budget (in thousands of US dollars) according to geographical level

Region of WHO	Geographical level									Total budget ^a (% of total)
	Headquarters			Regional			Country			
	Regular budget	Other sources	Subtotal	Regular budget	Other sources	Subtotal	Regular budget	Other sources	Subtotal	
Headquarters	5 073	23 000	28 073							28 073 (13%)
African Region				2 945	23 000	25 945	2 994	92 000	94 994	120 939 (55%)
Region of the Americas				104	4 000	4 104	498	8 000	8 498	12 602 (6%)
South-East Asia Region				1 966	5 000	6 966	703	13 000	13 703	20 669 (10%)
European Region				200	3 000	3 200	1 119	7 000	8 119	11 319 (5%)
Eastern Mediterranean Region				786	3 000	3 786	563	7 000	7 563	11 349 (5%)
Western Pacific Region				504	3 000	3 504	661	9 000	9 661	13 165 (6%)
Total	5 073	23 000	28 073	6 505	41 000	47 505	6 538	136 000	142 538	218 116 (100%)
Percentage by geographical level			13%			22%			65%	100%

^a Excludes about US\$ 6 million allocated to other WHO departments from the UNAIDS Unified Budget and Workplan).

5.1.2 Proportion of spending on treatment and prevention activities

In order to incorporate a major set of activities to scale up HIV/AIDS treatment and care, WHO will dramatically increase the spending in terms of both total dollars and the percentage of the budget allocated to treatment-related activities. Treatment-specific spending will increase from about US\$ 5.9 million (10% of the programme budget) in 2002–2003 to US\$ 109.0 million (50% of the programme budget) in 2004–2005. At the same time, WHO will continue to accelerate its efforts and associated spending in support of prevention-related activities. Spending on prevention-specific activities will increase from about US\$ 35.4 million (60% of the programme budget) in 2002–2003 to US\$ 54.5 million (25% of the programme budget) in 2004–2005.

Attempting to identify resources allocated to treatment and prevention is complicated by the fact many activities are cross-cutting and support both of these important priorities. For example, many of the normative and country capacity-building interventions in key technical areas required for ensuring a comprehensive response to HIV/AIDS cut across both prevention and treatment. These include HIV testing and counselling, developing entry points, links with malaria and TB control activities, advocacy, programme communication and work on strategic information, including surveillance, and monitoring and evaluation.

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Some activities can be designated as specific to treatment or prevention. For example, harm reduction, preventing mother-to-child transmission and targeted interventions for vulnerable populations may be considered prevention interventions. MTCT-Plus, antiretroviral therapy for children, adherence support, postexposure prophylaxis and other clinical care activities may be designated as specific to treatment.

Using these criteria, Table 6 estimates the spending allocated to treatment, cross-cutting and prevention activities during 2002–2003 and 2004–2005.

Table 6. WHO spending (millions of US dollars) on HIV/AIDS treatment and prevention, 2002–2005

Biennium	Treatment		Cross-cutting		Prevention		Total
	% of budget	Spending (index versus previous biennium, 2002–2003 = 100)	% of budget	Spending (index versus previous biennium, 2002–2003 = 100)	% of budget	Spending (index versus previous biennium, 2002–2003 = 100)	Spending (index versus previous biennium, 2002–2003 = 100)
2002–2003	10	5.9 (100)	30	17.7 (100)	60	35.4 (100)	59.0 (100)
2004–2005	50	109.0 (1847)	25	54.5 (308)	25	54.5 (154)	218.1 (369)

5.1.3 Allocation of spending across activity areas

WHO will continue to deliver expected results across its five key functional areas (strategic information, advocacy and policy, technical and normative guidance, country capacity-building, and operations research and knowledge management) in 2004–2005. However, country-level activity will be preferred wherever possible. Further, WHO will ensure that the right work is being done at the most appropriate level of the Organization.

Table 7 summarizes planned spending across the five functional areas, with the addition of programme management. A full 36% of total spending will be applied towards building capacity at the country level. Spending is reasonably consistent across the three organizational levels, with two exceptions. Country offices spend more on capacity-building and less on normative guidance than WHO headquarters. This pattern is very consistent with the expectations of the roles of the different levels as described in Section 3.

Table 7. WHO 2004–2005 HIV/AIDS budget according to the amount (in millions of US dollars) and percentage allocated to each functional area

Functional area	Level							
	Countries		Regions		Headquarters		Total WHO	
	Amount	%	Amount	%	Amount	%	Amount	%
Strategic information	17.1	12	5.7	12	3.7	13	26.5	12
Advocacy and policy	22.8	16	5.7	12	3.4	12	31.9	14
Technical and normative guidance	11.4	8	4.8	10	6.7	24	22.9	11
Country capacity-building	57.0	40	14.7	31	7.0	25	78.7	36
Operations research and knowledge management	7.1	5	2.4	5	2.5	9	12.0	6
Programme management	27.1	19	14.2	30	4.8	17	46.1	21
Total	142.5	100	47.5	100	28.1	100	218.1	100

5.2 Staffing

WHO's ability to undertake the activities described in this document – including activities to support realization of the “3 by 5” target – requires a dedicated team of professionals appropriately dispersed across the three levels of the organization and experienced in HIV/AIDS, antiretroviral therapy, health planning, public health and partnership development.

Assuming that funding is provided to support the total programme budget of US\$ 218.1 million, WHO projects a total HIV/AIDS staffing across the organization of 415. This total, as shown in Table 8, comprises a combination of international professional staff (249), national programme officers (76) and administrative support staff (90). About 53% of the planned staff will be based in WHO country offices, 28% at regional offices and 19% at WHO headquarters. However, the country and regional offices will be equipped with substantial activity budgets totalling US\$ 116.2 million, which can also be used to hire additional required staff on a short-term or contractual basis.

In a typical “3 by 5” focus country for scaling up antiretroviral therapy, WHO projects placing teams of 4–20 staff members, comprising a “3 by 5” country officer, reporting to the WHO country representative or liaison officer and responsible for leading the HIV/AIDS team on the ground. The team will be supported by several international professional staff and nationally recruited technical staff along with an appropriate complement of administrative support staff. The international and national professional staff will bring a variety of technical skills to the team such as expertise in antiretroviral therapy, laboratories, drug supply chain management, health systems, capacity-building, training and monitoring and evaluation. The specific number and mix of skills will be determined on a country-by-country basis by the WHO representative and the “3 by 5” country officer in consultation with the government and partner organizations present, based on a thorough understanding of the national scale-up plan.

Regional office WHO HIV/AIDS teams will also be strengthened so that they can provide necessary technical backstopping and support to the country-based staff and maintain direct support to non-focus countries that need occasional guidance but that do not require full-time dedicated HIV/AIDS staff.

HIV/AIDS staffing at headquarters will be reduced from current levels and will focus on the tasks that are best performed at a global level, such as normative guidance, global data and information management, policy issues and coordination with partners at a global level.

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Table 8. Staffing distribution and costs and activity spending (in millions of US dollars) based on the 2004–2005 WHO programme budget for HIV/AIDS

	International professional staff	National programme officers	Administrative support staff	Total staff	Activity budget
Country offices	106	76	38	220	98.7
Regional offices	83	0	32	115	17.5
Headquarters	60	0	20	80	4.9
Total	249	76	90	415	121.1
Staff costs	87.0	6.0	4.0	97.0	
Total budget					218.1

5.3 Resource needs

Putting the 2004–2005 WHO programme budget into perspective leads to a recognition that an investment of slightly more than 1% of the total estimated US\$ 20 billion needed to deliver a comprehensive response to HIV/AIDS over the same two-year period¹² will enable WHO to provide leadership, guidance and technical assistance to countries so that these resources are most effectively turned into results.

Importantly, of the US\$ 218.1 million 2004–2005 programme budget, only US\$ 18.1 million comes from WHO's regular budget. This means that US\$ 200 million must be raised from other sources.

As of July 2004, WHO had secured US\$ 156 million of the required US\$ 218 million, leaving a funding gap of US\$ 62 million. Funds secured so far include the generous pledge of CAD 100 million (US\$ 72 million) by the Government of Canada, announced on 10 May 2004, as well as contributions from Sweden and the United Kingdom.

There is an immediate need to front-load the remainder of this investment in WHO given the urgency of moving ahead in countries now so that the "3 by 5" target can be met on schedule. In other words, although donations arriving late in the biennium will be gratefully received, they will not help the organization deliver the "3 by 5" target. Countries and other funding organizations considering a donation are respectfully asked to do so now.

As this funding gap is met and activity scaled up, WHO will be called upon to do more and may submit additional appeals for funding beyond the US\$ 218.1 million on a country-by-country basis as specific needs are further defined and better understood.

In 2004–2005, WHO is receiving US\$ 21.5 million from the UNAIDS Unified Budget and Workplan funded by a number of bilateral donors. Of this amount, about US\$ 6 million is directed to other WHO clusters and departments to do important HIV/AIDS work in a variety of fields including child and reproductive health, blood safety and microbicide and vaccine research. The remainder of the US\$ 21.5 million is included in the total of US\$ 156 million secured so far.

As a result of the previous WHO policy of mainstreaming HIV/AIDS activities throughout the Organization, in addition to the US\$ 218.1 million for staffing and activities led by the Department of HIV/AIDS at WHO headquarters and regional and country office HIV/AIDS budget items, additional clusters and departments at WHO headquarters support HIV/AIDS activities that require additional funding requirements not presented here. WHO is currently reviewing and consolidating this work under the overall coordination of the Department of HIV/AIDS.

¹² Schwartländer B et al. Resource needs for HIV/AIDS. *Science*, 2001, 292:2434–2436.

6. Technical and managerial oversight

This section describes the steps WHO is taking to measure global progress in scaling up a comprehensive response to HIV/AIDS, report on activity in its own areas of work and ensure accountability to its Member States, donors and the international community.

6.1 Strategic and Technical Advisory Committee

A Strategic and Technical Advisory Committee is being created at WHO headquarters to independently evaluate scientific and technical aspects of the HIV/AIDS area of work. The Strategic and Technical Advisory Committee will review, from a scientific and technical viewpoint, WHO collaboration with and support to countries' efforts to respond to the HIV/AIDS epidemic, including providing guidance on policies, strategies and technical support. It will also advise on priorities among the possible areas of activity related to HIV/AIDS in the context of a) the WHO mandate and corporate strategy, b) the programmes of UNAIDS and its cosponsors, c) trends in the HIV/AIDS epidemic and d) the health-sector response to the epidemic. The Strategic and Technical Advisory Committee will consist of 20–25 members to be appointed by the WHO Director-General, taking into consideration diversity and balance of professional background, gender, geographical representation, international standing and affiliations. Members will include representatives of nongovernmental, community-based and faith-based organizations and organizations of people living with HIV/AIDS.

6.2 Annual meeting of the “3 by 5” Global Partners Group

WHO held meetings of the “3 by 5” Global Partners Group in November 2003 and May 2004 specifically to discuss scaling up antiretroviral therapy and to plan the joint action needed to realize the “3 by 5” target. The Group will meet at least annually to share information and update partners on WHO's plans, activities and progress related to HIV/AIDS.

6.3 Monitoring and reporting on progress

6.3.1 “3 by 5” milestones

The “3 by 5” strategy document lists 15 milestones representing key indicators of progress in scaling up global treatment, with baselines (where available) at December 2003. WHO will report on progress against these milestones every six months, beginning in July 2004 for the period January 2004–December 2005.

6.3.2 Progress reporting by country

Progress in scaling up antiretroviral therapy and accelerating prevention by country will be regularly and periodically reviewed and maintained on the WHO web site using selected country measures consistent with the globally agreed “3 by 5” monitoring and evaluation indicators. These reviews will enable a group of partners and peers to assess overall progress for each country, to identify opportunities for improvement and to refine national scale-up plans.

Country progress reporting will be supported by ongoing maintenance and improvement of the country profiles.

6.3.3 Programme budget reconciliation

WHO will report its total spending on HIV/AIDS every six months comparing global, regional and country-level activity with the WHO HIV/AIDS Plan and the programme budget.

6.3.4 Monitoring and evaluation

Tracking and reporting of key indicators that measure the degree the WHO HIV/AIDS Plan for 2004–2005 has been achieved will include:

- funding;
- staffing at country and regional offices;
- activity budgets at country and regional offices;
- number of countries that have put the “three ones” principles into operation for treatment scale-up;
- number of requests for technical assistance supported; and
- selected indicators of health systems performance.

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Annex 1

HIV prevalence, HIV mortality, antiretroviral therapy needs and targets for the 49 “3 by 5” focus countries

Region	WHO focus country	Estimated number of people living with HIV/AIDS (0–49 years), end 2003 ^a	Estimated adult prevalence of HIV/AIDS (15–49 years), end 2003 ^a	Estimated annual deaths from AIDS (0–49 years), 2003 ^a	Estimated total number needing antiretroviral therapy in 2005 ^b	“3 by 5” treatment target (50% of estimated need)	Antiretroviral therapy target declared by country for end 2005	Estimated number of people receiving antiretroviral therapy (15–49 years), June 2004	Antiretroviral therapy coverage
AFR	Angola	240 000	3.9%	21 000	32 000	16 000	5 500	700	2.2%
AFR	Botswana	350 000	37.3%	33 000	60 000	30 000	55 000	18 000	30.0%
AFR	Burkina Faso	300 000	4.2%	29 000	43 000	21 500	20 000	2 000	4.7%
AFR	Burundi	250 000	6.0%	25 000	38 000	19 000	12 500	2 186	5.8%
WPR	Cambodia ^c	170 000	2.6%	15 000	28 000	14 000	12 800	3 389	12.1%
AFR	Cameroon	560 000	6.9%	49 000	85 000	42 500	not declared	8 660	10.2%
AFR	Central African Republic	260 000	13.5%	23 000	39 000	19 500	not declared	1 000	2.6%
WPR	China	840 000	0.1%	44 000	100 000	50 000	30 000–50 000	7 400	7.4%
AFR	Côte d'Ivoire	570 000	7.0%	47 000	78 000	39 000	not declared	2 025	2.6%
AFR	Democratic Republic of the Congo	1 100 000	4.2%	100 000	160 000	80 000	not declared	2 500	1.6%
AFR	Ethiopia	1 500 000	4.4%	120 000	200 000	100 000	93 000	4 500	2.3%
AFR	Ghana	350 000	3.1%	30 000	52 000	26 000	30 000	716	1.4%
AMR	Guatemala	78 000	1.1%	5 800	12 000	6 000	not declared	2 740	22.8%
AFR	Guinea	140 000	3.2%	9 000	16 000	8 000	20 000	500	3.1%
AMR	Haiti	280 000	5.6%	24 000	40 000	20 000	5 000–10 000 (end 2004)	1 370	3.4%
SEAR	India ^{d,e}	NA	NA	NA	710 000	355 000	100 000	21 000	3.0%
AFR	Kenya	1 200 000	6.7%	150 000	220 000	110 000	95 000	11 000	5.0%
AFR	Lesotho	320 000	28.9%	29 000	54 000	27 000	28 000	1 000	1.9%
AFR	Malawi	900 000	14.2%	84 000	130 000	65 000	not declared	3 760	2.9%
AFR	Mozambique	1 300 000	12.2%	110 000	190 000	95 000	21 000	2 840	1.5%
SEAR	Myanmar	330 000	1.2%	20 000	42 000	21 000	10 000	200	0.5%
AFR	Namibia	210 000	21.3%	16 000	29 000	14 500	not declared	400	1.4%
AFR	Nigeria	3 600 000	5.4%	310 000	520 000	260 000	15 000	17 000	3.3%
EUR	Russian Federation ^f	860 000	1.1%	NA	71 000	35 500	not declared	1 800	2.5%
AFR	Rwanda	250 000	5.1%	22 000	36 000	18 000	not declared	2 140	5.9%
AFR	South Africa	5 300 000	21.5%	370 000	750 000	375 000	not declared	20 000	2.7%
EMR	Sudan	400 000	2.3%	23 000	43 000	21 500	20 000	400	0.9%
AFR	Swaziland	220 000	38.8%	17 000	32 000	16 000	12 000	3 200	10.0%
AFR	Uganda	530 000	4.1%	78 000	110 000	55 000	60 000	20 000	18.2%
EUR	Ukraine ^g	360 000	1.4%	20 000	45 000	22 500	2 100	170	0.4%
AFR	United Republic of Tanzania	1 600 000	8.8%	160 000	260 000	130 000	220 000	1 650	0.6%
WPR	Viet Nam	220 000	0.4%	9 000	22 000	11 000	15 000	1 000	4.5%
AFR	Zambia	920 000	16.5%	89 000	140 000	70 000	100 000	8 500	6.1%
AFR	Zimbabwe	1 800 000	24.6%	170 000	290 000	145 000	55 000	6 000	2.1%
Subtotal	High-burden countries	27 308 000		2 251 800	4 677 000	2 338 500	1 061 900	179 746	3.8%

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Region	WHO focus country	Estimated number of people living with HIV/AIDS (0–49 years), end 2003 ^a	Estimated adult prevalence of HIV/AIDS (15–49 years), end 2003 ^a	Estimated annual deaths from AIDS (0–49 years), 2003 ^a	Estimated total number needing antiretroviral therapy in 2005 ^b	"3 by 5" treatment target (50% of estimated need)	Antiretroviral therapy target declared by country for end 2005	Estimated number of people receiving antiretroviral therapy (15–49 years), June 2004	Antiretroviral therapy coverage
AMR	Belize	3 600	2.4%	<200	440	220	not declared	29	6.6%
AMR	Costa Rica	12 000	0.6%	900	2 500	1 250	not declared	1 654	66.2%
EMR	Djibouti	9 100	2.9%	770	1 200	600	1 370	94	7.8%
AMR	El Salvador	29 000	0.7%	2 200	4 700	2 350	not declared	1 212	25.8%
AMR	Guyana	11 000	2.5%	1 100	2 000	1 000	not declared	251	12.6%
AMR	Honduras	63 000	1.8%	4 100	7 400	3 700	not declared	1 421	19.2%
SEAR	Indonesia	110 000	0.1%	2 400	7 100	3 550	10 000	1 500	21.1%
EUR	Kazakhstan	16 500	0.2%	<200	460	230	not declared	49	10.7%
EUR	Kyrgyzstan	3 900	0.1%	<200	48	24	not declared	0	0.0%
AMR	Nicaragua	6 400	0.2%	<500	930	465	not declared	19	2.0%
AMR	Panama	16 000	0.9%	<500	2 200	1 100	not declared	1 530	69.5%
EMR	Somalia	NA	NA	NA	NA	NA	not declared	0	NA
EUR	Tajikistan	<200	<0.1%	NA	NA	NA	not declared	0	NA
EUR	Uzbekistan	11 000	0.1%	<500	770	385	not declared	0	0.0%
EMR	Yemen	12 000	0.1%	NA	NA	NA	not declared	0	NA
Subtotal	Regionally strategic countries	303 700		13 570	29 748	14 874	11 370	7 759	26.1%
TOTAL	Estimated total for 49 focus countries	27 611 700		2 265 370	4 706 748	2 353 374	1 073 270	187 505^h	4.0%
	Estimated total for all countries except those in western Europe, the United States, Canada, Australia, New Zealand and Japan				5 500 000	3 000 000		440 000	8.0%

AFR: African Region; WPR: Western Pacific Region; AMR: Region of the Americas; SEAR: South-East Asia Region; EUR: European Region; EMR: Eastern Mediterranean Region. NA: not available.

- ^a The WHO/UNAIDS Working Group on Surveillance and Estimates generates estimates for number of people living with HIV/AIDS, adult prevalence rate and annual deaths from AIDS using Spectrum software.
- ^b The estimated total number needing antiretroviral therapy is based on the estimated two-year mortality plus 80% of those currently receiving treatment.
- ^c Cambodia has estimated the number of people living with HIV/AIDS as 157 500 and antiretroviral therapy need as 22 000 based on calculations by the National Center for HIV/AIDS, Dermatology and STD (NCHADS).
- ^d For India, the current number of people on antiretroviral therapy need is an average between an independent coverage survey and the country profile data.
- ^e For India, the declared antiretroviral therapy target refers to the country's commitment to begin treatment in April 2004 but not to a specific target date of the end of 2005.
- ^f The Russian Federation has estimated the need for antiretroviral therapy to be 139 000 based on calculations made by their Federal AIDS Center.
- ^g Ukraine's country-declared target is for March 2005.
- ^h The difference between the 187 505 people receiving antiretroviral therapy in the 49 focus countries and the global number of 440 000 people receiving therapy is accounted for by approximately 250 000 people on treatment in about 120 other developing countries and countries in transition. Of these approximately 120 countries, the following have relatively large estimated numbers of people on antiretroviral therapy: Brazil (140 000), Argentina (25 131), Mexico (21 498), Thailand (13,000), Colombia (12 000), Venezuela (9 525), Romania (5 500), Chile (4 032), Malaysia (2 700), Peru (1 900), Bahamas (1 884), Poland (1 800), Senegal (1 600), Cuba (1 293).

Annex 2

Resolution WHA57.14

of the World Health Assembly, 22 May 2004

Scaling up treatment and care within a coordinated and comprehensive response to HIV/AIDS

The Fifty-seventh World Health Assembly,

Having considered the report on HIV/AIDS;¹³

Noting with great concern that by the end of 2003 about 40 million people were living with HIV/AIDS, the pandemic had claimed an estimated 3 million lives in 2003, and that HIV/AIDS affects women and children with particular severity;

Also concerned that, although about 6 million people in developing countries need antiretroviral treatment, only 440 000 currently receive it;

Noting with concern that other health conditions also cause high morbidity and mortality in developing countries;

Acknowledging that antiretroviral therapy has reduced mortality and prolonged healthy lives and that the feasibility of delivering antiretroviral treatment has been demonstrated in several resource-constrained settings;

Recognizing that treatment and access to medication for those infected and affected by HIV/AIDS, as well as prevention, care and support are inseparable elements of a comprehensive health-sector response at the national level, and require adequate financial support from States and other donors;

Recognizing that social stigma, discrimination, lack of affordability of antiretroviral medicines, economic constraints, limitations in health care capacity and human resources are some of the major impediments to access to treatment and care and social support for people living with HIV/AIDS;

Also recognizing the need to further reduce the costs of antiretroviral medicines;

Recalling the Declaration of Commitment on HIV/AIDS adopted at the United Nations General Assembly special session on HIV/AIDS (27 June 2001), which acknowledges that prevention of HIV infection must be the mainstay of national, regional and international responses to the epidemic and calls for significant progress, by 2005, in implementing comprehensive care strategies, including for access to antiretroviral drugs;

Recalling also resolution WHA55.12 on the contribution of WHO to the follow-up of the United Nations General Assembly special session on HIV/AIDS, resolution WHA55.14 on ensuring accessibility of essential medicines, resolution WHA56.27 on intellectual property rights, innovation and public health, and resolution WHA56.30 on the global health-sector strategy for HIV/AIDS;

Recalling and recognizing the Programme of Action adopted at the International Conference on Population and Development (Cairo, 1994), commitments made at the World Summit for Social Development

¹³ Document A57/4 submitted to the Fifty-seventh World Health Assembly.

(Copenhagen, 1995) and the World Summit for Children (New York, 1990), the Beijing Declaration and Platform for Action (1995), the Declaration on the Elimination of Violence against Women (1993), and the Millennium Declaration (2000), their recommendations and respective follow-ups and reports;

Noting with satisfaction the agreement of 25 April 2004 among development partners to improve coordination and harmonization in the response to HIV/AIDS at the country level, through the “Three Ones” principle, namely, one agreed HIV/AIDS action framework that provides the basis for coordinating the work of all partners; one national AIDS coordinating authority, with a broad-based multisectoral mandate; and one agreed country-level monitoring and evaluation system;

Recognizing the central role of the health sector in the response to HIV/AIDS and the need to strengthen health systems and human capacity development so that countries and communities may contribute fully to realization of the global targets set out in the Declaration of Commitment on HIV/AIDS and to develop public health systems with a view to minimizing the emergence of drug resistance;

Underlining the importance of WHO’s work, including through the WHO-initiated procurement, quality and sourcing project, to facilitate access by developing countries to safe, effective and affordable antiretroviral drugs and diagnostics at the best price;

Recalling the Declaration on the TRIPS Agreement and Public Health adopted at the WTO Ministerial Conference (Doha, November 2001), and welcoming the decision taken by the General Council of WTO on 30 August 2003 on the implementation of paragraph 6 in that Declaration;¹⁴

Acknowledging WHO’s special role within the United Nations system to combat and mitigate the effects of HIV/AIDS, its responsibility in the follow-up of the Declaration of Commitment on HIV/AIDS and, as a cosponsor of UNAIDS, in leading United Nations efforts in relation to treatment and care for HIV/AIDS and playing a strong role in prevention;

Welcoming the progress made by many Member States in beginning to scale up treatment for HIV/AIDS in their countries;

Welcoming also the increased support of Member States for programmes to combat HIV/AIDS;

1. WELCOMES the Director-General’s “3 by 5” strategy to support developing countries, as part of WHO’s follow-up to the comprehensive global health-sector strategy for HIV/AIDS, in securing access to antiretroviral treatment for 3 million people living with HIV/AIDS by the end of 2005, and notes the importance of mobilizing financial resources from States and other donors for WHO to achieve this target;
2. URGES Member States, as a matter of priority:
 - (1) to establish or strengthen national health and social infrastructure and health systems, with the assistance of the international community as necessary, in order to assure their capacity to deliver effectively HIV/AIDS prevention, treatment, care and support services;
 - (2) to strengthen national planning, monitoring and evaluation systems in order to deliver HIV/AIDS prevention, treatment, care and support services within the context of the overall national health strategy, ensuring an appropriate balance between services for HIV/AIDS and all other essential health services;
 - (3) to pursue policies and practices that promote:
 - (a) sufficient and adequately trained human resources with the appropriate skillmix to invoke a scaled-up response;
 - (b) human rights, equity, and gender equality in access to treatment and care;
 - (c) affordability and availability, in sufficient quantities, of pharmaceutical products of good quality, including antiretroviral medicines and medical technologies used to treat, diagnose and manage HIV/AIDS;
 - (d) accessible and affordable treatment, testing and counselling with informed consent, prevention and care services for all, without discrimination, including the most vulnerable or socially disadvantaged groups of the population;
 - (e) good quality and scientific and medical appropriateness of pharmaceutical products or medical technologies for treatment and management of HIV/AIDS, irrespective of

¹⁴ Document WT/L/540, available at <http://docsonline.wto.org>.

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- their sources and countries of origin, inter alia by making the best use of WHO's list of prequalified drugs that meet international quality standards;
- (f) further investments in medicines, including microbicides, diagnostics and vaccine research, in social science and health systems research, and in traditional medicines and possible interactions with other medicines, in order to improve effective interventions;
 - (g) development of health systems designed to promote access to antiretroviral medicines and to facilitate adherence to treatment regimens with a view to minimizing drug resistance as well as protection of patients against counterfeit medicines;
 - (h) integration of nutrition into a comprehensive response to HIV/AIDS;
 - (i) promotion of breastfeeding in the light of the United Nations Framework for Priority Action on HIV and Infant Feeding and the new WHO/UNICEF Guidelines for Policy-Makers and Health-Care Managers;
- (4) to consider, whenever necessary, adapting national legislation in order to use to the full the flexibilities contained in the Agreement on Trade-Related Aspects of Intellectual Property Rights;
 - (5) to apply the "Three Ones" principle with a view to improving coordination and harmonization in the response to HIV/AIDS;
 - (6) to encourage that bilateral trade agreements take into account the flexibilities contained in the WTO TRIPS Agreement and recognized by the Doha Ministerial Declaration on the TRIPS Agreement and Public Health;
3. REQUESTS the Director-General:
- (1) to strengthen the key role of WHO in providing technical leadership, direction and support to health systems' response to HIV/AIDS, within the United Nations system-wide response, as a cosponsor of UNAIDS;
 - (2) to take action within the framework of the "Three Ones" principle:
 - (a) to provide support to countries in order to maximize opportunities for the delivery of all relevant interventions for prevention, care, support and treatment of HIV/AIDS and related conditions, including tuberculosis;
 - (b) to support, mobilize and facilitate efforts of developing countries to scale up antiretroviral treatment in a manner that focuses on poverty, gender equality, and the most vulnerable groups, within the context of strengthening national health systems while maintaining a proper balance of investment between prevention, care and treatment;
 - (c) to provide guidance on accelerating prevention in the context of scaled-up treatment, in line with the global health-sector strategy for HIV/AIDS;
 - (3) to take measures to improve access of developing countries to pharmaceutical and diagnostic products to diagnose, treat and manage HIV/AIDS, including by strengthening WHO's prequalification project;
 - (4) to ensure that the prequalification review process and the results of inspection and assessment reports of the listed products, aside from proprietary and confidential information, are made publicly available;
 - (5) to support developing countries in improving management of the supply chain and procurement of good-quality AIDS medicines and diagnostics;
 - (6) to provide support to countries to embed the scale-up of the response to HIV/AIDS into a broad effort to strengthen national health systems, with special reference to human resources development and health infrastructure, health system financing and health information;
 - (7) to provide a progress report on implementation of this resolution to the Fifty-eighth World Health Assembly, through the Executive Board.

Annex 3

WHO Constitution, Article 2

In order to achieve its objective, the functions of the Organization shall be:

- (a) to act as the directing and coordinating authority on international health work;
- (b) to establish and maintain effective collaboration with the United Nations, specialized agencies, governmental health administrations, professional groups and such other organizations as may be deemed appropriate;
- (c) to assist Governments, upon request, in strengthening health services;
- (d) to furnish appropriate technical assistance and, in emergencies, necessary aid upon the request or acceptance of Governments;
- (e) to provide or assist in providing, upon the request of the United Nations, health services and facilities to special groups, such as the peoples of trust territories;
- (f) to establish and maintain such administrative and technical services as may be required, including epidemiological and statistical services;
- (g) to stimulate and advance work to eradicate epidemic, endemic and other diseases;
- (h) to promote, in cooperation with other specialized agencies where necessary, the prevention of accidental injuries;
- (i) to promote, in cooperation with other specialized agencies where necessary, the improvement of nutrition, housing, sanitation, recreation, economic or working conditions and other aspects of environmental hygiene;
- (j) to promote cooperation among scientific and professional groups which contribute to the advancement of health;
- (k) to propose conventions, agreements and regulations, and make recommendations with respect to international health matters and to perform such duties as may be assigned thereby to the Organization and are consistent with its objective;
- (l) to promote maternal and child health and welfare and to foster the ability to live harmoniously in a changing total environment;
- (m) to foster activities in the field of mental health, especially those affecting the harmony of human relations;
- (n) to promote and conduct research in the field of health;
- (o) to promote improved standards of teaching and training in the health, medical and related professions;
- (p) to study and report on, in cooperation with other specialized agencies where necessary, administrative and social techniques affecting public health and medical care from preventive and curative points of view, including hospital services and social security;
- (q) to provide information, counsel and assistance in the field of health;
- (r) to assist in developing an informed public opinion among all peoples on matters of health;
- (s) to establish and revise as necessary international nomenclatures of diseases, of causes of death and of public health practices;
- (t) to standardize diagnostic procedures as necessary;
- (u) to develop, establish and promote international standards with respect to food, biological, pharmaceutical and similar products;
- (v) generally to take all necessary action to attain the objective of the Organization.

Annex 4

Roles and responsibilities of UNAIDS Cosponsors¹⁵ and the UNAIDS Secretariat in the “3 by 5” Initiative

The Committee of Cosponsoring Organizations of the Joint United Nations Programme on HIV/AIDS (UNAIDS) has agreed upon the roles and responsibilities of the UNAIDS Secretariat and Cosponsors in scaling up antiretroviral therapy and their respective contributions to realizing the “3 by 5” target. Although these are not intended to be mutually exclusive and certain activities may be undertaken by more than one agency, they offer guidance to agency staff and the international community based on the agencies’ respective mandates and areas of expertise.

International Labour Organization (ILO)

- Advocating treatment by mobilizing its tripartite constituency: governments, employers and workers
- Promoting direct access to HIV treatment in the workplace, with integration of prevention, through dissemination of the Code of Practice on HIV/AIDS and the World of Work
- Expanding access to HIV care, treatment and support through occupational health services and community outreach programmes
- Advocating and promoting the extension of social protection to improve access to HIV/AIDS care and treatment
- Identifying and implementing innovative health and life insurance schemes to sustain access to HIV/AIDS care and treatment
- Supporting training and capacity-building in countries through its network of field offices
- Identifying and promoting innovative strategies to address the needs in the informal economy and small and medium-sized enterprises
- Promoting public and private partnerships to extend workplace programmes to communities through co-investment.

UNAIDS Secretariat

- Participating in planning and developing the “3 by 5” Initiative, including at executive level, and participating through staff in the “3 by 5” core team, working groups, costing activities, meetings with WHO regional office and country staff, technical and operational guideline development, and joint “3 by 5” events for World AIDS Day
- Supporting the “3 by 5” Initiative through the core functions of leadership and advocacy, strategic information, tracking, monitoring and evaluation, engaging civil society and mobilizing partners, and mobilizing resources
- Mobilizing country-based support and coordination through United Nations country theme groups on HIV/AIDS and United Nations country coordinators, including facilitating entry and undertaking WHO emergency team missions in countries, mobilizing other partners within United Nations expanded country theme groups on HIV/AIDS such as civil society, donors and the private sector and promoting effective communication and coordination at the country level.

¹⁵ The Office of the United Nations High Commissioner for Refugees became a Cosponsor of UNAIDS on 25 June 2004. The Committee of Cosponsoring Organizations will therefore update this list in July, 2004.

United Nations Children's Fund (UNICEF)

- Procuring and delivering antiretroviral drugs, including global pharmaceutical supply networks, diagnostic equipment and supplies
- Strengthening the capacity of health services, including providing technical assistance to countries, advising on overall health system reform, providing competitive cost estimates for antiretroviral drugs, drug forecasting, procurement, supply management and distribution systems
- Advocating at the global and country levels for increased access to care and treatment of women, children and young people identified through MTCT-Plus and adolescent-friendly health services
- Supporting the scaling up of MTCT-Plus programmes and establishing links with care and treatment programmes
- Promoting voluntary testing and counselling linked to MTCT-Plus and adolescent-friendly health services
- Supporting links between orphans and care and treatment programmes
- Modelling paediatric care and treatment programmes
- Supporting effective communication on treatment literacy

United Nations Development Programme (UNDP)

- Developing capacity, including enhancing skills needed for the performance of health care professionals, civil society actors, private sector professionals and community health workers
- Promoting community mobilization and ownership of the "3 by 5" Initiative to favour decision-making at the community level
- Advocating at the global and country levels and identifying ways in which the requirements for treatment are adequately reflected in the work of the United Nations Development Programme on development planning and governance
- Collaborating on the facilities set up for drugs (AMDS), especially in the area of developing the capacity of countries to ensure the availability of drugs in the context of intellectual property rights and the World Trade Organization TRIPS Agreement
- Identifying ways in which assessments include different dimensions of making a large-scale programme work – governance challenges, institutional effectiveness and strengthening systems
- Promoting the strengthening of capacity among local and regional organizations and cooperation within and between developing countries

United Nations Educational, Scientific and Cultural Organization (UNESCO)

- Providing assistance and capacity-building for the development of comprehensive plans in response to the pandemic by ministries of education that include information about and access to treatment both in and out of school settings
- Promoting laws, policies and programmes that combat stigma and discrimination against AIDS-affected and HIV-infected students and teachers
- Advocating treatment, including through culturally sensitive education and communication messages and through its extensive networks of journalists
- Linking prevention and treatment and integrating treatment information in prevention education
- Promoting treatment access as part of comprehensive AIDS programming among teachers and in school settings
- Promoting a rights-based approach to prevention and treatment for all young people, including those not enrolled in school

United Nations Office on Drugs and Crime (UNODC)

- Advocating treatment, especially HIV treatment, as part of overall treatment and rehabilitation for injecting drug users
- Strengthening the capacity of drug dependence treatment personnel in antiretroviral therapy
- Strengthening the capacity of prison health services in antiretroviral therapy
- Advocating the inclusion of the victims of trafficking in persons, especially women and young girls, in antiretroviral therapy
- Supporting the inclusion of HIV treatment education and literacy as part of drug dependence prevention and treatment programming

Scaling up treatment and accelerating prevention

United Nations Population Fund (UNFPA)

- Advocating on the prevention, treatment and care continuum, including the essential role of prevention within the “3 by 5” Initiative
- Promoting equitable access to treatment, emphasizing young people and women, priority access for HIV-positive pregnant women, and meeting the special sexual and reproductive health needs of HIV-positive women
- Building capacity on HIV prevention as a component of antiretroviral therapy delivery
- Utilizing infrastructure for the delivery of reproductive health services, such as those related to maternal and child health, preventing mother-to-child transmission, adolescent-friendly services, sites for services for sexually transmitted infections and for family planning, as entry points for voluntary HIV counselling and testing and antiretroviral drug delivery or as conduits for referral to antiretroviral drug delivery points
- Promoting voluntary HIV counselling and testing, especially in reproductive health service settings
- Promoting male and female condoms for preventing HIV and sexually transmitted infections as an integral part of delivering antiretroviral therapy services
- Providing procurement services for preventive commodities (male and female condoms, HIV test kits, drugs for treating sexually transmitted infections and safe delivery kits) and technical expertise and related tools in forecasting and procurement

World Bank

- Providing funding through the Multi-Country HIV/AIDS Program for Africa and Treatment Acceleration Program for comprehensive AIDS programming, including treatment, through both governments and nongovernmental organizations
- Mobilizing indigenous communities through individual grants
- Engaging WHO and United Nations system country-based staff in the Multi-Country HIV/AIDS Program for Africa programming and including “3 by 5” in Bank country missions
- Mobilizing all sectors in countries in “3 by 5” activities
- Sharing experience through expertise in and guidelines on procurement
- Promoting allocating debt relief savings towards health system and AIDS programming, including treatment
- Promoting access to treatment under a rights-based approach

World Food Programme (WFP)

- Advocating treatment, especially HIV/AIDS treatment, to alleviate the impact of HIV/AIDS on food insecurity in high-prevalence countries and in poor populations
- Providing nutritional support as part of preventing mother-to-child transmission and MTCT-Plus programmes for food-insecure populations
- Supporting HIV/AIDS treatment programmes by providing food to food-insecure people living with HIV and their families
- Supporting HIV/AIDS treatment programmes for children living with HIV/AIDS
- Supporting HIV/AIDS treatment programmes with logistics and other transport and storage capacity and expertise

World Health Organization (WHO)

- Providing overall leadership and advocacy for “3 by 5” within the United Nations system
- Supporting national authorities in effectively coordinating “3 by 5” activities in countries
- Coordinating normative guidance and developing standardized procedures and tools for delivering antiretroviral therapy
- Developing standardized tools for tracking the performance of antiretroviral therapy programmes and for the surveillance of antiretroviral drug resistance
- Supporting countries in strengthening the capacity of the health sector to effectively deliver antiretroviral therapy

- Supporting the development of human resource capacity at the country level
- Providing technical support to countries in developing national “3 by 5” targets, strategies and implementation plans
- Supporting countries in mobilizing sufficient resources to implement national “3 by 5” strategies
- Establishing and maintaining AMDS
- Coordinating operations research on models for antiretroviral therapy delivery
- Tracking overall progress towards “3 by 5”