What countries need

Investments needed for 2010 targets

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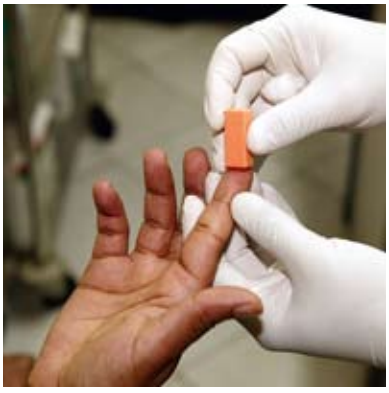

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What countries need

The global economic crisis has forced governments, civil society and even individuals to re-examine their investments and find innovative and often bold measures to ameliorate the situation.

Stimulus plans are injecting billions of dollars into national economies. But behind every job loss statistic there is a human face and a family that is hit at a personal level. Behind every announced stimulus package is the hope that the situation will improve. The global AIDS movement understands this well.

HIV has rendered families poorer than they were before. Children have been taken out of school, jobs have been lost, and cattle and property sold in order for those infected to access treatment.

However, as we move towards universal access to prevention, treatment, care and support, people living with HIV will be able to return to work, orphans will return to school, young people will have learnt to protect themselves from HIV, mothers will have delivered babies free from HIV, and communities most affected by the epidemic will be rejuvenated.

Universal access to HIV prevention, treatment, care and support by 2010 is the stimulus package that governments agreed to when they adopted the political declaration on HIV/AIDS at the United Nations General Assembly in 2006. Realizing this goal is essential to achieve Millennium Development Goal 6 of halting and reversing the spread of HIV by 2015; its achievement will have a positive impact on the other Millennium Development Goals that address gender equity, child and maternal survival and the alleviation of poverty.

Since 2001, there has been substantial progress in delivering HIV services to millions of people, especially in low- and middle-income countries. Today, nearly four million people are on antiretroviral treatment. By the end of 2007, the annual number of new HIV infections had fallen to 2.7 million from 3 million in 2005. New infections among children have dropped thanks to rapid scale up of services to prevent mother-to-child transmission of HIV. Young people in many parts of the world are waiting longer to become sexually active, having fewer sexual partners, or using more condoms. And millions of children orphaned by AIDS now have access to social support and protection.

An estimated US$ 13.7 billion was invested in the AIDS response in 2008. Today, many countries rely on The Global Fund for AIDS, Tuberculosis and Malaria to finance their national AIDS programmes. The Global Fund is an innovative mechanism for delivering resources to communites that need investments for their AIDS programmes. To reach the goal of universal access, it is imperative that the Global Fund is fully funded.

So far, 111 countries have set targets for achieving universal access. These targets are ambitious and achievable. There are less than 23 months to reach them.

Country-defined targets for 2010

People living with HIV, community groups, civil society organizations, governments and international organizations in more than 130 countries participated in a country-led process to set ambitious targets for achieving universal access. This process gave national leaders and a wide range of participants in the response to HIV the opportunity to better understand HIV transmission patterns, identify obstacles, revisit existing systems of programme delivery, ascertain community needs and select priority interventions. This renewed clarity about the unique aspects of the epidemic in each country, and the responses that would be most effective, has helped shape targets and milestones.

Country-set targets:

- respond to local needs—each country's targets are unique to their epidemic;
- include milestones that are based on countries increasing potential and capacities to scale up;
- are underscored by an analysis of obstacles and possible solutions; and
- have real ownership from a broad range of national stakeholders.

Universal access

What is universal access? Universal access signifies both a concrete commitment and a renewed resolve among people the world over to reverse the course of the epidemic. Universal access provides the platform on which people in need can access various HIV services. However, it does not imply that there will be, or should be, 100% utilization by all individuals of every HIV prevention, treatment, care and support intervention.

Rather, through the universal access movement, a worldwide commitment has been made to make measurable, sustained advances towards a higher level of coverage for the most effective interventions needed to manage the diverse epidemics across countries.

The basic principles that define universal access include that services must be equitable, accessible, affordable, comprehensive and sustainable over the long-term.

Long-term, predictable financing is critical to maximize progress towards universal access. Achieving universal access will require the mobilization of investments substantially greater than the US$ 13.7 billion available for HIV programmes in low- and middle-income countries in 2008. It will also require a disciplined resource allocation process to ensure the provision of crucial services, in particular those for prevention.

Each country will reach their specific programmatic targets at different times, with most countries achieving universal access for priority services by 2010. While most countries have set ambitious targets, some have not. Figure 1 shows the range among country level targets for a set of priority programmatic interventions. Figure 2 shows some examples of country set targets for 2010. Countries with less ambitious targets must revisit them urgently. Doing so will provide an opportunity to accelerate progress towards universal access.

This demonstrates that most countries have set a target of 80% coverage of antiretroviral treatment and prevention of mother-to-child transmission programmes, which is widely accepted as a standard definition of universal access for these interventions—that is one that is achievable and will also have the most significant impact on the population served. In regions with concentrated epidemics, countries have given priority to availability of services for key populations at higher risk of exposure to HIV such as sex workers, injecting drug users, and men who have sex with men. In sub-Saharan Africa, countries have given special emphasis on setting targets aimed at providing social support interventions for orphans and other vulnerable children.

Just the process of setting targets for universal access itself has spurred many countries into action. Already, some countries, such as Botswana, the Lao People's Democratic Republic, and Namibia, have made dramatic progress, in particular towards achieving universal access to antiretroviral treatment.

Kenya launched a 'Rapid Results Initiative' at the end of 2006, requesting districts to establish treatment targets to be achieved in 100 days. The results were extraordinary. Nearly all districts exceeded their targets, demonstrating the motivating power and prioritization of action that can result from target-setting.

Ethiopia has adopted strategies to ensure decentralized provision of services, training no fewer than 50 000 community members. Other countries such as India, Nigeria and the United Republic of Tanzania are making good progress, but if their current pace continues they are unlikely to achieve their universal access treatment target before 2012 or even later.

FIGURE 1

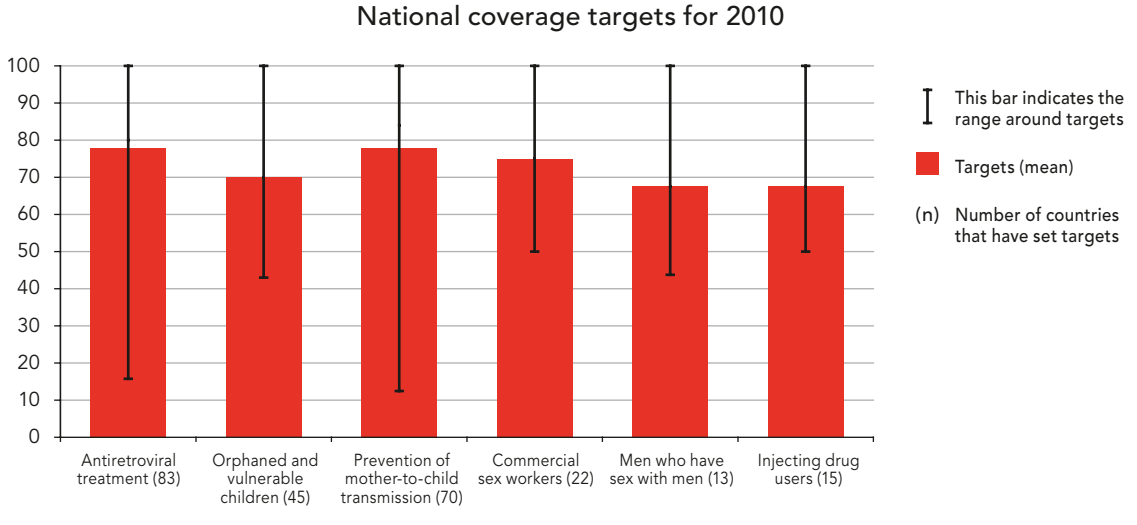
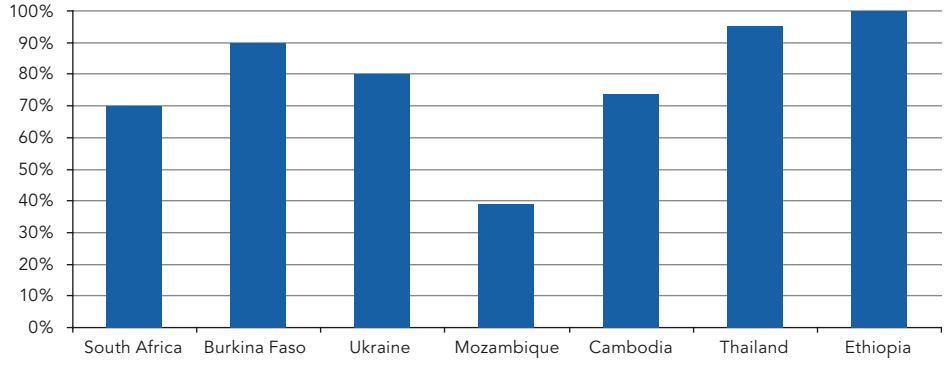


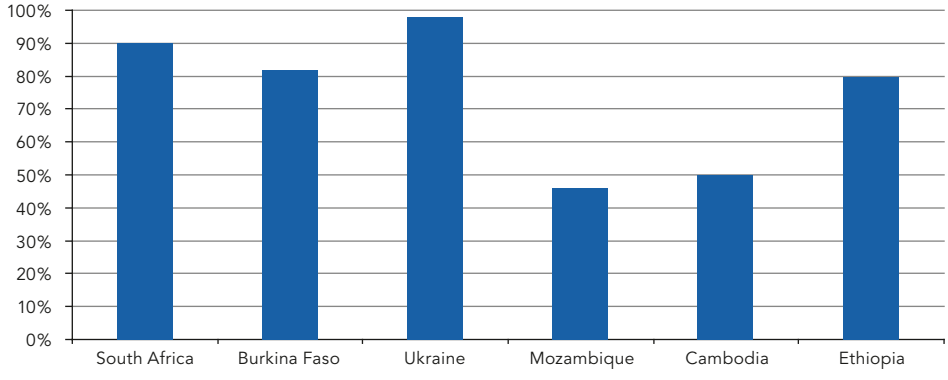
FIGURE 2

Country examples of 2010 targets

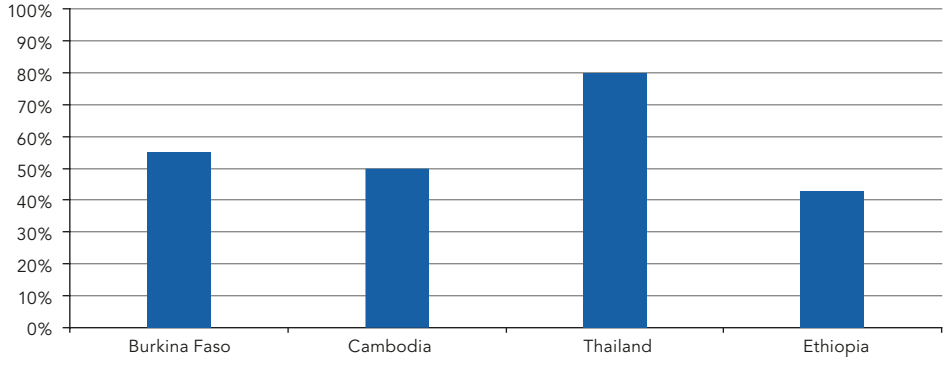
Percentage of women, men and children with advanced HIV infection who are receiving antiretroviral combination therapy



Percentage of HIV positive pregnant women receiving a complete course of antiretroviral prophylaxis to reduce the risk of mother-to-child transmission



Percentage of orphans and vulnerable children aged under 18 living in households that have received a basic support package



Investments needed for 2010

Based on the country-defined targets for 2010, it is estimated that an investment of US$ 25.1 billion (US$ 18.9 billion–US$ 30.5 billion) will be required for the global AIDS response in 2010 for low- and middle-income countries. Of this total, nearly US$ 11.6 billion will be required for HIV prevention and US$ 7 billion for treatment. Table 1 provides a breakdown of the investments required by different programmatic areas.

It is anticipated that domestic public sources will supply roughly one third of the investments needed globally. External sources will be required to cover the remaining two thirds needed, with most assistance focused on low-income countries, especially in sub-Saharan Africa. Figure 3 provides a regional breakdown of investments required.

As in the past, upper-middle-income countries, particularly in Asia, Eastern Europe and Latin America, will continue to finance almost the whole of their national AIDS responses from domestic sources.

Of the total investments required, approximately one third are for activities addressing behavioural change, social drivers of the epidemic, social mitigation and other services that are managed outside of the health sector through multisectoral programmes. Yet, these estimates do not fully cover certain programmatic areas that are not directly linked to HIV service delivery. For example, some measures to address violence against women have been included in these estimates. However the entire range of actions required for comprehensively addressing violence against women such as legal reform and economic empowerment for women, and basic education for girls must be financed through other development initiatives.

Another one third is aimed at strengthening health systems. The weakness of health systems is a major obstacle to scaling up to universal access to prevention, treatment, care and support. The components included in the investment needs estimates for health systems strengthening are outlined in Annex 2.

The remaining one third will go towards HIV specific health services, such as programmes to reduce mother-to-child HIV transmission, blood safety, and provision of antiretroviral therapy for those in need. A full list of these services can be found in Annex 2.

Table 2 provides a breakdown of the estimated investment needs by category of activity. The priority services chosen for each country were based on UNAIDS prevention guidelines, which call on countries to prioritize programmatic interventions according to the type of national epidemic. For example, countries with generalized epidemics have an urgent need to scale up prevention services for young people—those engaged in risky behaviours, and address the underlying societal causes that promote risk-taking behaviour. Whereas countries with concentrated epidemics are advised to focus first on providing services and programmes to the most-at-risk populations, including sex workers, their clients, injecting drug users, and men who have sex with men. Annex 1 provides a list of priority HIV interventions by epidemic type.

Table 1: Investments needed for HIV services in 132 low- and middle-income countries (US$ billion)

Country-defined targets	2009	2010
Prevention	9.0	11.6
Treatment and care (including palliative care)	5.5	7.0
Orphans and vulnerable children	1.7	2.5
Programme support costs	3.4	3.7
Prevention of violence against women	0.2	0.3
Total	19.8	25.1
Ranges	(16.2 – 23.7)	(18.9 – 30.5)

FIGURE 3

Regional breakdown of investments needed (US$ billion)

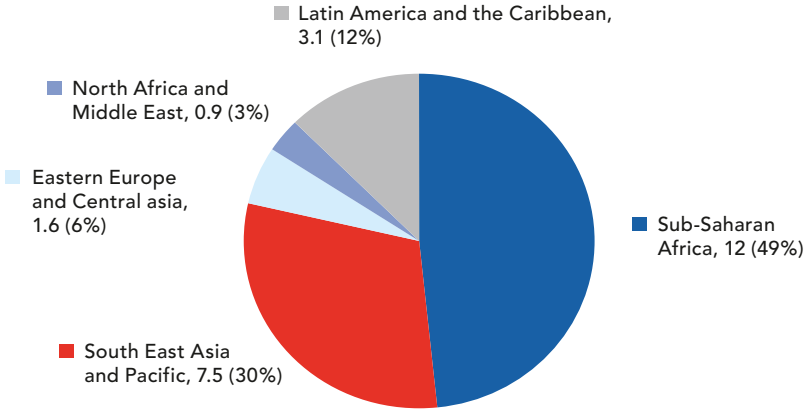


Table 2: Investments needed – categorized by activity area (US$ billion)

Country-defined targets	2009	2010
HIV-specific health services	7.6	9.4
Health system strengthening and cross-cutting activities [a]	7.5	9.2
Multisectoral services	4.7	6.5
Total	19.8	25.1

[a] Cross-cutting activities include: programme costs, strengthening of civil society, global advocacy and coordination, policy, human rights, and tackling stigma.

Photo UNAIDS / J. A. Wainwright

The investment needs for treatment and care cover more than the provision of antiretroviral treatment. They also include provider initiated testing and counselling (diagnostic and routine offer of testing), treatment and prophylaxis for opportunistic infections, nutritional support, laboratory testing, palliative care and the cost of drug-supply logistics. The costs for CD4 testing to monitor the response to antiretroviral therapy and disease progression are also included.

What can be achieved with the $25 billion?

With the achievement of country-defined targets of HIV-related services, in 2010 approximately 6.7 million individuals would be receiving antiretroviral treatment. More than 70 million pregnant women will be screened and receive prevention of mother-to-child transmission services; 20 million men who have sex with men, 7 million sex workers and 10 million people who inject drugs will receive HIV prevention services. Seven million orphans will be supported and nearly 8.1 billion condoms (male and female) distributed. This will result in averting 2.6 million new HIV infections, cutting HIV incidence by nearly 50% and averting 1.3 million deaths. (see Table 3)

Table 3: Expected outcomes and impacts if full investments were made on country-defined targets in 132 low- and middle-income countries by 2010 (million)

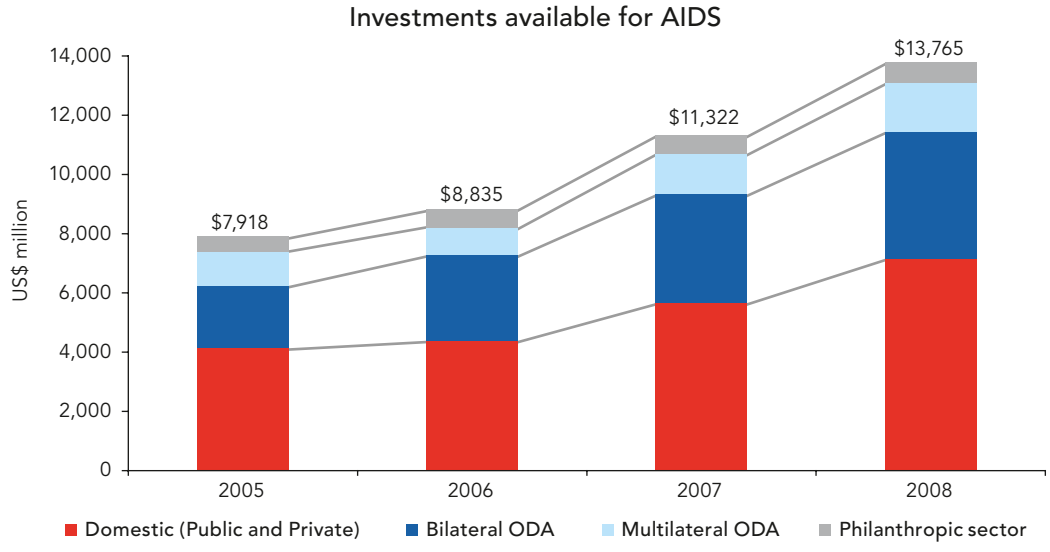
Number of new HIV infections averted (2009-2010)	2.6
Number of deaths averted (2009-2010)	1.3
People on antiretroviral treatment	6.7
Primary school teachers trained	1.0
Sex workers reached	7.5
Voluntary counselling and testing	40.9
Condoms provided	8,153.7
Workers reached in the workplace	46.2
Units of safe blood produced	42.6
Pregnant women offered comprehensive prevention of mother-to-child transmission services	74.5
Injecting drug users reached with harm-reduction programmes	9.6
Men who have sex with men reached	20.4
Prisoners reached	6.2
Safe injections provided	4,247.1
Male circumcisions performed	1.5
Orphans supported	6.7
People receiving treatment for opportunistic infections and palliative care	2.1

The economic crisis and impact on AIDS

The International Monetary Fund estimated in January 2009 that world economic growth will fall from 5.2% in 2007 to just 0.5% in 2009. Growth in the advanced economies is expected to shrink by 2% during 2009, and to slow from 8.3% (in 2007) to 3.3% in emerging and developing economies. Low-income countries will suffer from a reduction in employment and remittances (funds sent home by migrant workers) which will have a severe effect on poverty and on household capacity to meet health expenditures. At the same time, low-income countries will have less revenue and that will limit their ability to expand social-sector spending. Potentially this could have a significant impact on the global response to HIV. Globally, the largest sources of financing for HIV programmes at the end of 2008 were domestic expenditures in the affected countries (52%), direct bilateral cooperation (31%), multilateral institutions (12%) and the philanthropic sector (5%). The domestic funds include out-of-pocket spending by individuals and affected families and in 2008 were estimated to be nearly US$ 1 billion (Figure 4). Each source is vulnerable to the impact of the economic slowdown in a different way. Therefore innovative approaches have to be found to secure and increase the investments for the global AIDS response.

Photo UNAIDS

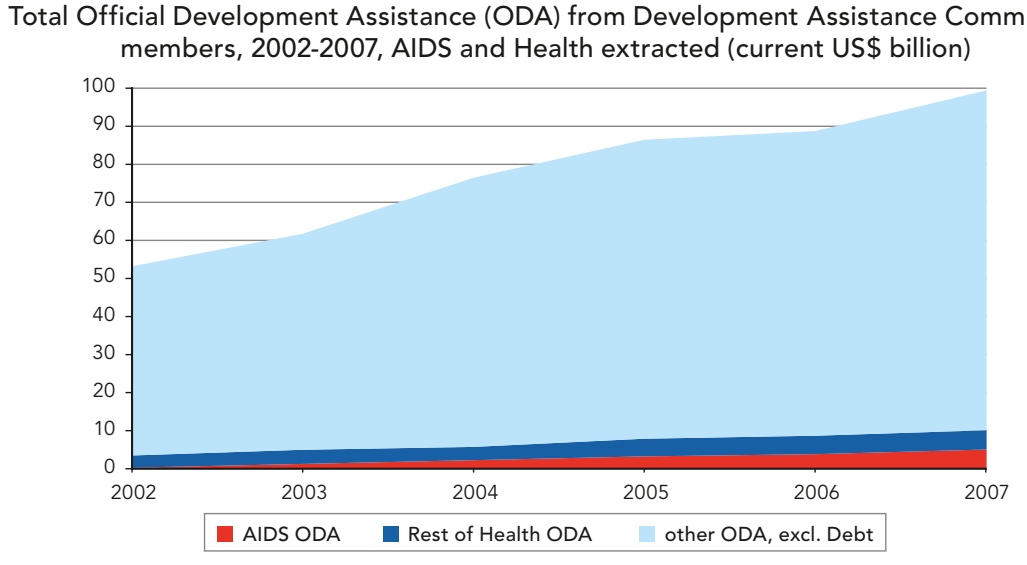
FIGURE 4



While fiscal and economic adjustments are likely to be a reality today, they should be made with a human face in mind, as the world cannot afford to diminish its effort to control and reduce the AIDS epidemic.

This means maintaining and expanding HIV programmes to save lives and protect human capacity. Long-term sustainable financing for HIV must be secured from both external and domestic sources. HIV programmes have to

FIGURE 5



Source: OECD/DAC CRS; data extracted on 2009/01/15 13:13 from OECD Stat (Excluding debt relief).

become more cost effective, unit costs have to be reduced and efficiencies in programme delivery have to be gained. In short, the money has to work better for people.

It is positive to note that none of the major donors have given any indication that the level of total Official Development Assistance or contributions to HIV programmes will be cut in the near future. Commitments must be honoured in the months to come.

Aid funding has grown steadily in recent years (Figure 5). Past experiences suggests that international social sector funding through Official Development Assistance has tended to be somewhat protected against falls in the economy. However, there has to be a constant monitoring of the situation.

Some low-income countries on the other hand may cut social sector expenditures in times of economic crisis. For this reason, the vulnerability of each country is different—it depends how much of its financing comes from domestic sources and how much from international sources, and also on how wealthy the country is compared to the needs of its HIV programmes.

For example, programmes in countries with high spending on AIDS that are mostly met from domestic sources (such as Botswana) will be vulnerable to their own reduced economic growth, but less immediately affected by changes in international aid funding. In contrast, countries with high spending on AIDS and high aid dependency (such as Haiti or Mozambique) have less scope to increase their domestic budget and will in addition be vulnerable to cuts in international funding.

Photo UNAIDS / J. D. Ly

In the medium term, it is prudent to expect that many countries will face additional demands on their domestic budgets and will seek more aid funding.

Conclusion

Achieving country-defined targets by 2010 presents an opportunity to change the pace of the response to the AIDS epidemic. It will help save lives—by putting more people on treatment, protecting babies and young people from getting infected, and ensuring that a whole generation of orphans will graduate from school. It will also build the foundation for sustaining the AIDS response for years to come, as well as contributing to the strengthening of health systems and increasing human resources. It will help reduce homophobia, stigma and discrimination, especially of the voiceless and marginalized. It will contribute to reducing violence against women and girls and empowering millions to protect themselves from HIV and sexual abuse.

It is clear that in today's financial climate, investments must be made wisely. But the human face must be kept in mind; behind each reduction or cutback is an individual, a family. To this end, money for AIDS must work better for people: programmes should be cost effective, more efficient in service delivery and unit costs reduced.

The investments required can be found, and recent achievements in treatment and prevention demonstrate what is possible.

What is needed today is stronger political will, paired with a deep appreciation of human rights. Universal access has to become a reality for the hundreds of millions of people who are vulnerable to HIV infection and the millions of people living with HIV and their loved ones. Investments already made in responses to AIDS are showing results. This is a time for scaling up, not scaling down.

Methodology for investment needs calculation

Investments required = number of people in need x coverage (the percentage of the population receiving the service) **x unit cost** (the cost to provide the service to one individual).

- The estimates of country needs were produced for 132 low- and middle-income countries and based on the type of epidemic and nationally established targets using the latest available data. Where countries have not defined targets for a particular area or service, a default set of globally determined targets were used to define universal access targets for the country.
- A costing model using an ingredients-based and bottom-up approach was utilized to estimate the annual costs for each programmatic intervention. Sixty activities were grouped into five categories: (1) prevention; (2) treatment and care; (3) orphan support; (4) programme support; and (5) interventions to prevent violence against women.
- Unit costs were primarily derived from publications, project descriptions and country specialist information. Regional averages were used for countries where there were no specific data. It was assumed that unit costs for prevention services will decline as programmes expand.
- The costs of those activities for which unit costs per capita were not relevant (e.g. management, operations research and monitoring and evaluation) were estimated by costing the standard activity ingredients.
- Categories of programmatic interventions were reconciled with the most recent UNAIDS guidance, including the UNAIDS prevention guidelines[1] and WHO guidelines for antiretroviral therapy for adults and adolescents.[2]
- In accordance with the emphasis in the UNAIDS prevention guidelines on addressing the drivers of the epidemic, the package of HIV prevention services costed include, for the first time, programme and policy responses that address the role of gender inequality in driving national epidemics. Such measures include programmes to promote gender equality, to train staff on gender awareness in programmes for voluntary counselling and testing, to prevent violence against women, and to provide comprehensive post-rape services, including post-exposure prophylaxis (PEP) for women who have been raped. The interventions included in this category are by no means exhaustive, but encompass promising approaches that are already being used.
- Prices for antiretroviral treatment were taken from the WHO database of prices for antiretrovirals.
- Investment needs estimates include children who were orphaned from all causes in sub-Saharan Africa. Experts in this area recommended that all orphans be included from sub-Saharan Africa because it is difficult to distinguish a child made an orphan by AIDS from a child made an orphan by other causes and ethically challenging to implement a service delivery programme that makes this distinction.[3,4] Outside sub-Saharan Africa, only orphans attributable to AIDS are included in the estimates.
- The country-defined universal access approach assumes a comprehensive task shifting approach for human resources and recruitment of additional staff, thus the need to employ the equivalent of 133 200 full-time health personnel between 2010 and 2015, e.g. 13 340 physicians and 36 100 nurses, and other selected health care staff.
- All investment needs are reported in constant 2007 US$.

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1 UNAIDS. UNAIDS action plan on intensifying HIV prevention, 2006-2007. Geneva, Switzerland 2006. UNAIDS. Practical Guidelines for Intensifying HIV Prevention: Towards Universal Access. Geneva 2007.

2 WHO. Antiretroviral therapy for HIV infection in adults and adolescents: Recommendations for a public health approach, 2006 revision.

3 As recommended by the UNAIDS Resource Needs Advisory Board during its meeting in Glion, Switzerland on 10 May 2007. The Advisory Board is composed of international economists and AIDS experts from donor and developing countries, civil society, United Nations agencies, including UNICEF, and other international organizations.

4 Stover J, Bollinger L, Walker N, and Monasch R. Resource needs to support orphans and vulnerable children in sub-Saharan Africa. Health Policy and Planning 2007; 22:21–27. (doi:10.1093/heapol/czl033)

Annex 1: Priority HIV prevention interventions and targets by epidemic type

Programmatic activity coverage (% unless otherwise stated)	Type of Epidemic		
	Low Level	Concen-trated	Generalized / Hyper-endemic
Communication for social and behavioural change			
Average number of mass media campaigns per year	2	4	5
Community mobilization			
Adults reached	0	0	70
Voluntary counseling and testing (VCT)[5]			
Maximum proportion population seeking VCT test each year	0.1	1	5
Met need for VCT	100	100	100
Youth interventions			
Primary teachers trained (max of 1/3 in each school)	30	45	100
Secondary teachers trained (max of 1/8 in each school)	30	45	100
Out of school youth reached, ages 6-11[6]	10	20	50
Out of school youth reached, ages 12-15	10	20	50
Interventions focused on sex workers and clients			
Sex workers reached by intervention each year	80	80	80
Average consistency of condom use	100	100	100
Condoms provided that are female condoms	5	5	5
Programmes focused on men who have sex with men (MSM)			
MSMs reached by intervention each year	80	80	80
Average consistency of condom use	80	80	100
Harm reduction interventions			
Injecting drug users receiving harm reduction intervention	80	80	80
Workplace interventions			
Workforce with access to HIV peer education	0	3	50
Condoms provided by workplace	10	10	10
Employers providing STI treatment	0	3	50
Men in workplace with symptomatic STIs treated	0	70	70
Women in workplace with symptomatic STIs treated	0	70	70
Vulnerable populations			
Prisoners reached	80	80	80

	Low Level	Concen-trated	Generalized / Hyper-endemic
Increased public sector condom provision			
Condom wastage during storage and distribution	10	10	10
Casual sex acts where condoms are used	80	80	80
Married persons with casual partners using condoms in marital sex	30	30	30
Condom social marketing			
Condoms distributed by social marketing programmes	25	25	25
Condoms provided that are female condoms	2	2	2
Improving sexually transmitted infections (STIs) management			
Male symptomatic STIs treated at clinics among those with access	60	75	100
Female symptomatic STIs treated at clinics among those with access	60	75	100
Syphilis among ANC attendees detected and treated	60	75	100
Prevention of mother-to-child transmission interventions			
Pregnant women attending ANC in facility tested	80	80	80
Women offered regimen who accept and complete it	90	90	90
Women testing HIV-positive who take infant formula	10	10	10
Male circumcision[7]			
Males 15-24 circumcised	0	0	80
Blood safety measures			
Units of blood for transfusion tested	100	100	100
Post-Exposure Prophylaxis (PEP)			
Met need for PEP	100	100	100
Safe injections (low-income, sub-Saharan Africa countries only)			
Immunizations using AD syringes (2007)	77	92	99
Reduction in number of unnecessary medical injections	25	25	25
Other injections using AD syringes (2007)	77	92	99
Universal precautions (low-income, sub-Saharan Africa countries only)[8]			
Health workers covered (2007)	77	92	99

[5] Client-initiated confidential voluntary counseling and testing (VCT): the resource needs were calculated based on anticipated demand which varied according the prevalence. Provider initiated testing and counseling (PITC) is included under treatment and care component.

[6] The target for out-of-school youth is limited to 50% because the investments required for peer outreach activities to this group (outreach worker serving 20-40 youths) beyond such levels would not be justified given the need to preferentially devote investments to provide schooling for this group.

[7] Scale-up to reduce half the difference between current male circumcision prevalence and 80% target.

[8] Universal precautions are shared across the health system, are not AIDS-specific and thus more relevant in countries with hyper-endemic and generalized HIV epidemics.

Annex 2.

Health systems strengthening components included in investment needs estimation

1. Universal precautions
2. Blood safety
3. Safe medical injections
4. Specific HIV-related laboratory monitoring
5. Opportunistic infection (OI) prophylaxis
6. Opportunistic infections' (OI) treatment
7. Basic health care for orphaned and vulnerable children
8. Monitoring and evaluation
9. Drug supply systems
10. Information technology
11. Upgrading and construction of infrastructure
12. Upgrading laboratory infrastructure and new equipment
13. Construction of new health centers
14. Human resources training

HIV-related health services included in investment needs estimations

1. Male circumcision
2. Management of sexually transmitted infections (STIs)
3. Prevention of mother-to-child transmission
4. Post-exposure prophylaxis (health care setting)
5. Adult first line antiretroviral drugs
6. Child first line antiretroviral drugs
7. Adult second line antiretroviral drugs
8. TB and antiretroviral treatment
9. First line labs
10. Second line labs
11. Nutrition
12. First line service delivery
13. Second line service delivery
14. Opportunistic infections treatment
15. Palliative care
16. Cotrimoxazole
17. Opportunistic infections prophylaxis
18. Provider initiated testing and counselling
19. STI screening
20. Counselling for people living with HIV and families/partners

Notes

Notes

UNAIDS, the Joint United Nations Programme on HIV/AIDS, brings together the efforts and resources of ten UN system organizations to the global AIDS response. Cosponsors include UNHCR, UNICEF, WFP, UNDP, UNFPA, UNODC, ILO, UNESCO, WHO and the World Bank. Based in Geneva, the UNAIDS secretariat works on the ground in more than 80 countries worldwide.

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