Report of the expert meeting

"3 by 5" What Are the Implications?

Organized by the Royal Tropical Institute, Aids Fonds and Share-Net
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Contents

Abbreviations and Acronyms

AIDS	Acquired immunodeficiency syndrome
ANC	Antenatal care
ART	Anti-retroviral therapy
ARV	Anti-retroviral
CBO	Community Based Organisations
DFID	UK Department International Development
IEC	Information, Education and Communication
GFATM	Global Fund to Fight AIDS, tuberculosis and Malaria
GIPA	Greater Involvement of People Living with HIV/AIDS'
HAART	Highly Active Anti Retroviral Therapy
HIV	Human immunodeficiency virus
KIT	Royal Tropical Institute
MFO	Co-financing organisations
MSF	Médecines Sans Frontières
NGO	Non-governmental organization
PEPFAR	President's Emergency Plan For AIDS Relief
PMTCT	Prevention Mother to Child Transmission
PLWHA	People living with HIV/AIDS
SAN	Stop Aids Now!
SRH	Sexual and reproductive health
TB	Tuberculosis
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNGASS	United Nations General Assembly Special Session
UNMDG	United Nations Millennium Development Goals
USAID	United States Agency for International Development
WHO	World Health Organization
World Bank MAP	World Bank Multi-Sector Aids Programme
VCT	Voluntary Counselling and Testing

Civil society - individuals and groups, organized or unorganized, who interact in the social, political and economic domains and who are regulated by formal and informal rules and laws. Civil society offers a dynamic, multilayered wealth of perspectives and values, seeking expression in the public sphere (UNDP Website 2004).

The "3 Ones" principle for the coordination of national AIDS responses:

- **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 multi-sectoral mandate;
- **one** agreed country-level monitoring and evaluation system.

Preface

"There has never been such an overwhelming move to increase access to medicines in such a short period". In one sentence, a conference speaker had given participants a view of the magnitude of the debate that conference organizers, KIT, Share-Net and Aids Fonds, ignited when they asked: "3 by 5: what are the implications?" The HIV/AIDS pandemic had been put in the right dramatic context without using dramatic effects. But by referring to the history of public health care, the speaker went beyond the limitations of the conference question, suggesting that traditional approaches will be far from sufficient to address the problem of HIV/AIDS.

And we are talking about a most traditional approach indeed. The advantages of vertical programmes, as well as their waste of resources through fragmented care, return to the stage. Perhaps it is a way to move rapidly, accepting that donors are not (or don't want to be!) aware that bringing the commodities is just a part of what a comprehensive war against HIV/AIDS requires.

At the same time, many governments in recipient countries realize that the promising support brings a lot of new requirements that cannot be met. The support obviously aims at an improved and expanded health care package, but with a rather narrow perspective.

Coordination between donors and between donors and recipients is generally poor. The burden of follow-up falls on the recipients' national health systems. Under these various pressures one sees the biggest need ever to strengthen the national health systems, and to provide the vital commodities as well as the vital knowledge and operational capacity in a coherent way. This process has only just started. One does not dare to imagine the light years of distance between decision makers in a donor consortium and the, often quite young, groups of People Living with AIDS or the Community Workers, who are not yet able to access the desperately awaited home-based care.

In view of all this, it is most laudable and even courageous that KIT, Share-Net and Aids Fonds have drawn attention to the urgent need for a strategy to build up networks that have access to basic information and resources. These networks should include key players, governments and donors, but should also extend to all levels of civil society. There may be an emphasis on health care but, again, this goes far beyond the limitations of the formal structures.

A lot has been said about the necessary mobilization of civil society, but often as a valuable extended arm of the established systems. In many places, there is no structure that coordinates civil society's role or its access to information or funds. These organisations might not even appear on lists of those who are part of the networks. Who takes the lead? This also means, who finances it?

The conference day provided a view of the broad experiences represented as well as an opportunity to build up a range of valid and valuable questions. The different organizations represented could not give the replies without involving the others, a core issue in the "3 x 5" initiative.

A major and rightful ambition of WHO in its initiative, is (and should be!) the coordination and balancing of the many support activities. Were this further shaped and expanded, it might show that WHO does not even have the experience or the capacity and certainly not the funds needed for that role.

In the meantime, most donors continue to "do their own thing" - all their funds committed (with limited coordination with others) and their activities mushrooming to an almost unacceptable level.

It was not surprising that many similar questions were brought to the table during this day of brainstorming. The meeting also noted the discrepancy between the high contributions of the Dutch government towards, for instance, UNAIDS and the Global Fund, and the low weight of the Dutch political voice.

The results of the conference were easily tied together as a basis for further action. A recently established regular liaison between the Ministerial Taskforce on HIV/AIDS and Reproductive Health and Share-Net will provide a good opportunity to discuss critical issues.

There will certainly be more conferences like this, on the same subject and with comparable or increased expertise. More information will surface and be shared, more questions may arise but the target will be the highly needed, coherent answers that will bind and benefit all committed parties.

KIT, Share-Net and Aids Fonds in close collaboration with other partners will definitely guide the next steps to be taken.

Jan Dik, chairman of the day

Summary of the Main Findings

The main findings of the meeting are presented below in arbitrary order:

- The WHO is applauded for its bold leadership in launching the “3 by 5” initiative, which offers hope of treatment for many people living with HIV/AIDS. There is now a need for the WHO to strengthen its in-country role in coordinating the patchwork of organizations involved in the struggle against HIV/AIDS. More technical support from the WHO is also needed. This is certainly what the WHO has in mind but I am not sure that this is what the conference fully supported. I suggest: The implementation of ARV treatment is funded through many channels, such as the global fund, the PEPFAR fund and other initiatives by bilateral donors involving many NGOs and government agencies. These initiatives need coordination at national and international level. The WHO is putting itself forward to coordinate in country initiatives and provide technical support. The success of this initiative, however, will depend on the willingness of other partners and national governments to accept this role.

- The “3 by 5” initiative has raised huge expectations in terms of hope for infected people; all efforts should be made to make this initiative work. Availability of treatment will help reduce the stigma attached to HIV/AIDS and have a positive impact on prevention due to people’s increased voluntary participation in counselling and testing.

- The present, often deplorable, state of human resources in health services raises serious concerns. Emphasis should be placed on real reinforcement of human resources, to counter any further depletion of staff. Availability of treatment for health care personnel is one measure that could improve retention.

- “3 by 5” will be effective only if it is comprehensive – spanning prevention, education, access to sexual and reproductive health care and follow-up care – and if it respects all human rights.

- Civil society, community groups and people living with HIV/AIDS, have key roles to play in the “3 by 5” initiative. They must demand the services they are entitled to receive, check providers and monitor the programmes. To fulfil these roles, they need an enabling environment, for which more technical and financial support is required. At the same time, HIV/AIDS has a direct impact on these actors. The past holds lessons on how community participation can be organized and on other aspects of the initiative.

- Pressure must be maintained for vaccine development and other preventive strategies, such as microbicides.

- Widespread implementation of the “3 Ones” principle would provide tremendous relief in administration, coordination and monitoring and evaluation for all receiving countries. It therefore needs to be supported.

- Procurement systems and supply management need to be strengthened in the receiving countries, to ensure that no out-of-stock situations arise for qualitative anti-retroviral treatments.

- The Dutch government's huge financial input in the struggle against HIV/AIDS is applauded. The meeting recommends that the Dutch make more use of the political power that goes along with such a significant financial contribution to influence policy formulation and implementation.

- The large number of people and organizations working on HIV/AIDS and sexual and reproductive health care in the Netherlands offer a rich trove of experience and knowledge. These actors should work more towards a shared agenda and increase their influence on Dutch policy regarding access to treatment.

1 Introduction

In 2003, the WHO started an initiative to expand access to HIV treatment. “3 by 5” is the name of the global target of providing anti-retroviral therapy (ART) to three million people living with HIV/AIDS in resource-limited countries by the end of 2005. It is a step towards the goal of providing universal access to treatment for all who need it. The WHO’s framework for emergency scaling up of anti-retroviral therapy contains 14 key strategic elements. These elements fall into five categories – the pillars of the “3 by 5” campaign: i) global leadership, strong partnership and advocacy; ii) urgent, sustained country support; iii) simplified, standardized tools for delivering anti-retroviral therapy; iv) effective, reliable supply of medicines and diagnostics; and v) rapid identification and application of new knowledge and successes.

The strategy also aims to develop guidelines for ensuring the quality of anti-retroviral drugs and to build country-level capacity for delivery and utilization of simple diagnostics for monitoring patient adherence to treatment as well as drug resistance. In the first six months of this strategy, progress was made towards the goal of increasing access to treatment. But much remains to be done, and urgently, if the world is to meet its target of providing treatment to three million people by the end of 2005.

The “3 by 5” target is an initiative that requires huge human, financial and institutional resources in scaling up already existing national treatment programmes. An estimated six million people living with HIV/AIDS in resource-limited countries are in urgent need of ART. Only 300,000 people currently have access to treatment. Achieving “3 by 5” will be a major step towards the goal of access to ART for all. Many resource-constrained countries have made a promising start by showing that ART can be implemented in resource-limited settings, and that it can be made affordable; but these efforts have mainly been conducted in pilot projects. There are serious doubts about the viability of this initiative, and several factors will be crucial for its success.

Furthermore, the “3 by 5” initiative has broad implications, such as the potential to shift emphasis from prevention to curative care, and from other health care needs to HIV/AIDS. It may also impact on human rights and equity and result in drug resistance.

Faced with the “3 by 5” strategy, Netherlands-based organizations working in HIV/AIDS prevention, care and treatment need a clear understanding of what it means in terms of health system requirements, human resources, compliance, adherence and equity aspects, as well as practicability and partnerships. Understanding its implications is essential to supporting the initiative.

The objectives of this meeting were therefore twofold:

- to exchange views and contribute from different angles to the insights regarding the various aspects, state of affairs and implications of the “3 by 5” initiative;
- to achieve clarity on what actions organizations can take in order to support this initiative and critically follow the process.

2 Morning Sessions

2.1 Opening
Catherine Hodgkin, Director, KIT Development Policy and Practice

Catherine Hodgkin opened the meeting with a warm welcome to all participants. She reminded the audience that it was only in 1980 that the first cases of HIV infection in San Francisco's gay community were published. Since then, the speed of events confronting the health and development communities has been enormous. Incredible advances have been made. Now, only 20 years later, there is the possibility to provide access to anti-retroviral therapy (ART), though problems still exist in coordination, overview, prioritization and administration. We may ask how the "3 by 5" initiative fits into already fragile health systems. In answer, we can say that the "3 by 5" initiative is not about pills, but about access to treatment. If it works, it can provide a new basis to reinforce struggling health services. There are many gaps and constraints, however, and the objective of this meeting is to see how we can overcome those gaps in seemingly impossible adverse situations.

2.2 Contextualizing the "3 by 5" Initiative
Pieter Streefland, KIT

The "3 by 5" initiative aims to provide ART to many people living with AIDS. This is possible because simple ways have become available to identify those in need and because straightforward treatment regimens and cheap drugs are obtainable. Treatment is life-long and requires a high level of adherence to the drug regimen to achieve a "private good" (individual health) and a "public good" (curtailing HIV/AIDS). Several points of concern can be raised:

- The people who intervene may have different objectives.
- Many countries will require a new organizational infrastructure to implement this long-term duty.
- Questions can be raised as to whether the organizations that rallied to get treatment to people living with HIV/AIDS are also suited to keep them on treatment.

The "3 by 5" initiative can be approached from a number of perspectives and issues.

Individual users' perspective

- Is it important to go into the details of particular lives/illness and treatment histories of each of the millions of people in need of ART?
- How can we deal with individual user aspects that touch on treatment/prevention outcomes (storage of drugs in homes, counselling of contacts)?
- Who will take responsibility and has the expertise to deal with treatment in context?

Regarding the obligation of accessibility:

- Are health services able to guarantee equity of access and detect the hidden sick?

Longitudinal and community perspective

- Adequate implementation of longitudinal programmes requires a long-term commitment.

- Organizations providing treatment need to be learning institutions, with appropriate maintenance, monitoring and use of records and stability in staff.
- How can we deal with the present situation, characterized by international donors, NGOs and national politicians and policymakers who have only a short-term outlook, who do not consider history relevant to solve new problems in health policies and who do not keep archives and have limited institutional memory?

Collective action to achieve a common good

- The global and national organizations financing procurement and distribution of anti-retrovirals to ill people in developing countries make up a multidimensional patchwork of alliances, personal networks, funds, foundations and multilateral institutions.
- This network is not transparent; it is unstable, ungovernable and unaccountable to people living with HIV/AIDS.
- The WHO should be pivotal in "3 by 5", but its role has been eroded during the past decade, as it has lost power, expert personnel and legitimacy.

Public health care under pressure

- In sub-Saharan Africa, public health services, the quality of care and trust among users has been diminished by the heavy disease load, scarcity of resources and a high turnover of personnel.

Unintended side effects

- There will be side effects of the "3 by 5" initiative, and these should be understood before undertaking a large upscale, since they could have a huge impact on the success of the intervention.

The poverty eradication imperative

- People on treatment are not always capable of earning a living. Timely assessment is needed of how following treatment people with HIV/AIDS can use new capabilities to enhance their living conditions.

Final points of concern

- Who will record the unintended and adverse effects of "3 by 5"? How open will the discussion be?
- Who will maintain pressure for vaccine development?
- The individual perspective should not be forgotten, and we should keep thinking about how to support all the health workers in the field.

2.3 The Implications of "3 by 5"

Marcel van Soest, World AIDS Campaign

Important achievements have been made with regard to treatment. Prices have gone down. Anti-retrovirals are now included on the WHO's list of essential drugs. International political commitments have been obtained: in the United Nations Millennium Development Goals, the UN General Assembly Special Session, the Global Fund, Doha (crucial in getting prices low), and the "3 by 5" initiative. Donors have committed themselves financially and programmes have been piloted successfully with low drug resistance outcomes.
Though past achievements have raised high expectations, trust has been undermined by delays in the delivery of promised dollars. This has politicized the AIDS movement, leading to NGOs becoming disconnected from real needs and

NGOs detracting from the ability to identify the key and sincere players. The current situation poses a real risk of detrimental fights and struggles within countries and between and within stakeholder groups.

In the process, too little attention is being given to Southern NGOs, and civil society is not being given real opportunities and sufficient resources to act upon their agendas. Despite all the verbal support, civil society still does not have the assistance it needs. Most crucial are the people living with HIV/AIDS, who must be put at the centre, not only as a strong voice pushing government but also as an integral part of planning, programmes and evaluation. Leadership must be given to the people living with HIV/AIDS – since the current lack of coordination at all levels results in poor and fragmented use of dollars. It is important to use the potential to scale up care and treatment, because this will increase prevention: encouraging people to come forward; reducing stigma and discrimination; increasing voluntary counselling and testing; and discouraging uncontrolled over-the-counter ART, which will certainly increase without proper and sustained treatment and care.

The situation in Kenya is illustrative of the implications of “3 by 5” for a country. Kenya has a population of 32.4 million people and an HIV/AIDS prevalence of 4.7-9.5% of adults 15 to 49 years of age. Presently, 11,000 Kenyans receive ART, 1,000 in the public sector and 10,000 in missions, NGOs and private facilities. Many large donors have intervened: the Global Fund, the World Bank Multi-Sector AIDS Programme, the President’s Emergency Plan for AIDS Relief, the US Agency for International Development (USAID) and the United Kingdom’s Department for International Development (DFID). These all have their different regulations and treatment guidelines, programme conditions, monitoring and evaluation procedures and anti-retroviral procurement rules. This multitude of rules and procedures raises questions of equity, efficiency and cost-effectiveness (six donors do their own procurement). Clearly, huge investments will be needed to have 110,000 people on treatment by 2005.

In September 2003, the Kenyan government still did not have a national treatment plan, and it does not have control over the pharmaceutical sector. Moreover, there is little attention for opportunistic infections and palliative care. The huge increase in promised donor money has here again politicized the AIDS issue, with the present focus seeming to be on the money rather than on the best strategy for getting people access to treatment. In Kenya, people living with HIV/AIDS have very little voice and there is little donor support for them. Stigma and discrimination are huge problems. There are no plans to invest in treatment preparedness, and adherence problems have surfaced in private sector and mission hospitals, with patient fall-out sometimes more than 50%. While mission hospitals and the private sector have been successful in getting treatment to patients, they are completely disconnected from community support services and networks that complete the care cycle.

The emergency of AIDS should be used to strengthen the “health system” approach and money should be invested to get a discussion underway among stakeholders on how to make such a system work. There is currently momentum to change things, but for Kenya to build on that momentum a number of conditions need to be put in place:

- greater support by donor countries in the fight against governmental corruption;
- improved cooperation to regulate and monitor the pharmaceutical sector;
- less focus on money only, with more attention on expanding existing successes with proven partners;

- guaranteed implementation of a real comprehensive approach, as NGOs fear that many will be left out;
- provision of ART free of charge.

In Kenya a lot has been achieved at a technical level, but too little has been accomplished strategically. There is no leader in providing technical assistance to health systems. The new Kenyan government and the “3 by 5” initiative could trigger change. The Netherlands is one of the donor countries making the largest contributions to fighting AIDS. The Dutch were the largest contributor to the Joint United Nations Programme on HIV/AIDS (UNAIDS) in 2003. But the Netherlands has so far failed to wield the political power it has accrued by being one of the biggest donors.

The Netherlands is home to a wide range of organizations with HIV/AIDS-related expertise: Medicines Sans Frontier, the PharmAccess International Foundation, the International Antiviral Therapy Evaluation Centre (IATEC), the Global Network of People Living With Aids (GNP+), Stop Aids Now!, Aidsfonds/Soa–AIDS NL, Share-Net, Dance4Life, AIDS Action Europe, and the World AIDS Campaign. We in the Netherlands must ask ourselves what are we doing with this knowledge and why is the Dutch government not accessing this expertise?

Are we doing enough?
How long will we accept Prime Minister Balkenende’s returning from the United States saying that the Netherlands will collaborate with the United States on the AIDS agenda? Perhaps the biggest shock was the lack of public outcry and anger among the HIV/AIDS-affected civil society here in the Netherlands. The lack of government consultation on the prospect of Dutch support for the US perspective is unacceptable. The lack of follow-up and reaction from civil society should also be questioned.

2.4 Discussion and Questions on the First Two Presentations

A point of discussion was whether the gender issue was stressed enough in the first presentation.
There appears to be wide agreement on the importance of gender issues. Women are often among the hidden sick. People on treatment should be linked to prevention and have access to sexual and reproductive health services.

The question was asked whether any epidemic has ever been successfully tackled with drugs. Various comments were made:
- A problem is that ART does not cure but cares.
- The presentations highlight the problems. Though “3 by 5” reveals the weaknesses of the system, we cannot sit back and do nothing.
- We do not know what effects treatment will have on the course of the HIV/AIDS epidemic. The effect of treatment may be quite different when applied to an epidemic that is still on the rise compared to one that is subsiding.

Both speakers stressed the importance of linking with home-based care, but home-based care is dependent on volunteers and is perhaps unsustainable. In South Africa, a study of the impact of home-based care showed that it makes life more difficult for women.

- We can learn a lot on how to deal with these kinds of problems from experiences from village health worker programmes. At the community level, we need people who can identify problems, who can guide. Home-based care is the only feasible option. Past experiences can shed light, for example, on whether to pay care-givers and how they can be linked with the health services.
- In Nigeria 20 years ago, home care-givers were paid something, but nowadays they do not get anything. People should get paid for work they do to benefit the community.

Since half of HIV patients are also infected with tuberculosis, why is there no promotion of collaboration with TB programmes? The TB programmes have gained a lot of experience over the years.

- A participant reported on a field visit to a public-sector comprehensive care programme in Kenya that started in April 2004. The programme had an enthusiastic team, incentives from donors and a willingness to increase the output and scale up to the national level.
- Someone else noted the lack of activism coming out of TB programmes; there are no real success stories of a good scale-up of treatment.

2.5 Scaling up HAART in Resource-Poor Settings
Pierre Humblet, Médecines Sans Frontières (MSF)

MSF started its first highly active anti-retroviral therapy (HAART) programme in 2000. By 2004, it had 43 programmes active in 20 countries in Africa, Asia and Latin America. The programmes range in size from 20 to 2,000 patients. Their objectives:

- to provide a holistic package of care specifically for HIV/AIDS and TB and for general health services;
- to implement and evaluate pilot projects to demonstrate that HIV/AIDS and TB treatment programmes can be effective;
- the current challenge to prove that it is possible to scale up these pilots to the country level.

MSF provides care within the framework of public health services. The question is, “Can an intervention for HIV/AIDS benefit the public health system as a whole?” The basic package of activities consists of information, education and communication; voluntary counselling and testing; prevention of mother-to-child transmission; management of opportunistic infections and TB; implementation of HAART; and provision of home-based care, nutritional support and community mobilization.

The programme in Thyolo District in Malawi

The example of Thyolo District in Malawi is illustrative of MSF’s experience in scaling up HIV prevention, care and treatment. Ten and a half million people live in Malawi. The country’s population is mainly rural and HIV prevalence is estimated at 10% for the general public and 19.8% for antenatal care attendants. MSF applies a district approach in HIV/AIDS prevention, care and treatment in Malawi, though with the additional aim of cross-fertilization to other districts and to the national level. Its targets for 2003-07 are to provide access to the whole continuum of care to at least half of the estimated 50,000 people living with HIV/AIDS in Malawi and access to ART for at least half of the country’s 7,000-8,000 people with AIDS. Most patients at the HIV/AIDS clinics are at stage 3 or 4. The villages are linked to the voluntary counselling and testing programmes, with people who test positive being referred to volunteers.

The annual budget of the programme in Thyolo District is 2.2 million euros, and MSF employs 60 staff. The money supports the overall functioning of the hospital, not only HIV/AIDS-related care. The hospital has faced severe staff shortages with more than half of the posts unfilled because staff died or were too sick to work. Immediate solutions were needed, like topping up salaries, offering training and giving staff at the Ministry of Health access to ART early in the programme. Further, MSF worked to mobilize communities and involved lay workers in the information, education and communication and voluntary counselling and testing aspects of the programme.

The Thyolo District programme has five main elements:

- *Information, education and communication.* A community information campaign is initiated before voluntary counselling and testing is begun at health centres.
- *Voluntary counselling and testing*. The process is simple, with counsellors themselves doing the testing (whole blood rapid testing) after providing counselling.
- *Prevention of mother-to-child transmission*.
- *Community-based care*. Social support, timely referral and follow-up encourage adherence to treatment. Home-based care is arranged for non-treatment periods.
- *ART*. Treatment is in the form of fixed drug combinations. Adherence is central and there are many procedures for ensuring it. There is a management of opportunistic infections protocol for nurses, articulation with other services and a decentralization process for ART. Malawi has an ambitious plan to start using one drug in 50 hospitals.

Challenges

A number of challenges remain in extending HIV/AIDS care and strengthening the health care system in resource-poor settings such as Malawi:

- Treatment is available in only a very limited number of places.
- Free care is essential to ensure adherence to treatment.
- Demand for ART continuously rises; as more people get informed and receive counselling and testing and are referred to the centres where ART is available.
- Whether public services will be able to deliver ART varies by country, depending mainly on management capacity and corruption. The challenge here is huge, since access to treatment means the difference between life and death.
- In general there is too little emphasis on prevention. MSF tries to link with other organizations. Access to care will boost prevention, since the prevention message comes across more easily where treatment is available.
- Prevention of mother-to-child transmission and treatment for children is still difficult for many.
- Free treatment sounds easy, but the practice is considerably different. Not only do patients need pills, but health care workers need laboratories as well.
- “3 by 5” is not only about ART, it is also about offering voluntary counselling and testing, prevention and strengthening basic health services.

Someone who had visited Malawi observed that “densely populated” is a relative concept, and even in the capital people tend not to return to the clinics. Could getting treatment to people at home be a solution for adherence?

- MSF has neither the experience nor the policy to do this. They try a 5-10 km reach and have a triage system, with a nurse checking on patients’ condition and complications. Volunteers are not a viable option for providing ART. It is

already a challenge to ensure quality care at the health centres and hospitals. To decentralize more will be difficult.

Many infected women hope to be able to deliver a healthy baby. Why is prevention of mother-to-child transmission so difficult?

- The mother and child health system is not functioning in many places. Many women do not return after the first consultation; 40% to 50% are not seen back before delivery. That makes it difficult to ensure that a mother gets the drugs she needs before delivery. Then there is also the issue of breastfeeding; and the impact on prevention is relatively small in terms of diminished infection rate. The cost-benefit of the intervention is quite low.

A participant was glad to hear the call to include young people for treatment.

- Many difficulties are involved in treating children. There are problems related to the delivery of drugs and there is a lack of adaptive drugs. Other questions relate to counselling and support for children. People wanted to be more comfortable with adults before starting with kids.
- Ensuring access to care for teenagers also presents difficult issues. It is important to link information on sex with information on AIDS and to start education of younger children in primary schools.

A participant was gratified to hear the remarks on sexuality. Although a holistic package of care was presented, nothing was said on the needs in sexual and reproductive health. Is MSF making a start on this? Prevention is most effective. Earlier there was a call for more donor money, but not much was said about increasing resources for prevention.

- The chairperson of the day replied that the “3 by 5” initiative includes elements of sexual and reproductive health and education.

We have been active in getting treatment to those in need, but in fact we are using a vertical approach in fighting the disease, while what we actually want to do is strengthen the health system. How can we capitalize on the spill-over to the larger health care system?

- This question of access to care is being discussed by people from various organizations. Although there seems to be a schism between people talking about access to health care in general and those discussing access to care for HIV specifically, this is a false debate. There can be no care for HIV if there is no basic health care service. However, access to care has not been given much attention in the past year. Health care professionals cannot yield miracles with nothing. Major investments in health are needed, not only to tackle the problem of HIV/AIDS but also to boost health services generally.
- The shortage of medical staff is the result of 20 years of structural adjustment and cannot be remedied with a magic bullet. We will have to solve the problems one by one. But the global picture still has to be taken into account.

The presentation skipped the issue of nutrition, while access to healthy food and safe water is a key aspect.

- All HIV patients in the MSF programme receive food packages as part of the treatment. Of course the picture is broader, but we cannot address all problems.

What will happen after 2007?

- MSF does not know what the situation will be after 2007, but that should not stop us from acting now. A four-year commitment for ART (2003-07) is a long commitment.
- Most countries now get their drugs through the Global Fund. In practice, there are too few actors, so MSF is also using money that comes through other funds.

3 Afternoon Sessions

3.1 Getting Medicines to the Poor: The Role of the Dutch
Guido Bakker, World Response

The first major conference on access to medicines was organized five years ago, right here in Amsterdam. At that time, anti-retroviral treatments were prohibitively expensive and generic competition was minimal. Also, there was virtually no funding available to treat HIV/AIDS in poor countries.

Then, in 2001, UN Secretary General Kofi Annan introduced the idea of creating a Global Fund to Fight Aids. Within one year, that fund was operational and had committed 5.3 billion dollars to fight AIDS, tuberculosis and malaria globally. With this dramatic increase of funding to fight AIDS, the WHO introduced its "3 by 5" programme. Other international organizations also up-scaled their AIDS activities.

The speed with which discussions surrounding access to medicines developed from industry and donor bashing to implementing large-scale programmes is unprecedented in the history of global public health. And that is a good thing.

Many obstacles to overcome
Despite the successes, however, there are still numerous obstacles to overcome in the fight against AIDS. Elites in poor and in wealthy countries are still sceptical and cynical. Even today it was questioned whether "we should really be putting people on anti-retrovirals". We have passed that point: people need treatment, so collect the necessary funding and provide the assistance required.

Medicine procurement and supply management have been neglected by international donors historically. Until recently, the World Bank was the (almost) exclusive financer of large-scale procurement of medicines. However, the World Bank has never put substantial emphasis on the development of sound procurement and supply management systems. This lack of capacity, both in terms of human resources and physical infrastructure, means that few countries are able to spend their newly received funds responsibly and quickly.

Furthermore, there is a lot of confusion among Global Fund recipients regarding procurement requirements. Recipients have had difficulties writing procurement plans, and many people are misinformed about what they can and cannot do. Lastly, major power struggles among elites are preventing programmes from gaining speed. The central question is always, "Who is in charge of the cash?" Elites in both recipient and donor countries are not always taking the decisions that would support rapid implementation.

What can the Dutch do?
The Dutch government has been financing drug access, but it has not leveraged its political power in the board rooms of the international organizations it supports. In addition to leveraging this political power, the Dutch Ministry of Foreign Affaires could expand its support for procurement and supply management.

Regarding Dutch NGOs and activists, there seems to be a need to refocus, to move away from raising money and towards providing operational support to recipient countries.

3.2 Community Involvement in "3 by 5"
Morolake Nwagwu, Treatment Action Movement, Nigeria

The WHO's vision of treating three million people by the year 2005 offers hope for a healthy and meaningful existence and productive life for many of Africa's people living with HIV/AIDS. Looking at the impact of the HIV/AIDS epidemic on populations, since 1995 the gap between the North and the South has been widening due to availability of ART in the North.

The Pan African Treatment Action Movement (PATAM) is a treatment activist group that was set up out of anger that people were dying and their leaders had failed them. The group was excited about the WHO's one million dollar contribution, since on its own it cannot pay staff and consumables.

The role of communities will become more important than ever before in treatment and care of people living with HIV/AIDS. Communities will be not only the heart but also the hands of this initiative. Much is needed: treatment education, treatment support and new models of community care. If people living with HIV/AIDS and communities are expected to shoulder more of the burden, they will require more resources in terms of money and education.

"3 by 5" is about local people filling the gaps. But this must be done together, since funding and support for NGOs is needed. Sufficient capacity needs to be built to enable people living with HIV/AIDS to participate in these processes. For their part, NGOs will need greater political and financial accountability. The idea is that they will become their own watchdogs, monitored by governmental and non-governmental stakeholders.

The WHO is not yet playing the role it should play in Nigeria. The WHO was supposed to work with the Global Network of People Living with HIV/AIDS (GNP+) and other NGOs to set up an advisory body on "3 by 5" by end 2003, but it never managed to reach the responsible person.

How to achieve "3 by 5"?
- Everyone must take ownership, provide links and fill gaps.
- Local activist groups must be provided the funding and support they need to take ownership of the process.
- Support organizations need to go beyond purchasing pills to help strengthen and support health systems.
- All must join in the campaign for debt relief. Governments are not paying teachers and doctors because the money coming in is going out to pay for debt.

- Cheaper AIDS drugs must be created and better access provided to affordable quality generics.

Access to life-saving medicines must go hand in hand with prevention of new infections. No one else should get infected. HIV/AIDS must not become another malaria, where the drugs are cheap in the private sector and free in the public sector, but no one invests in prevention. Never forget, “3 by 5” is not just another project or global cliché. It is about saving three million human lives. “Support us to support ourselves, to save our lives.”

3.3 Responding to Workforce Needs for Delivery of ART
Norbert Dreesch, WHO

An overview has been given of the challenges health systems face in human resources: an absolute shortage of health workers, poor training of care providers, poor working conditions and migration of qualified personnel, urban bias, low motivation and other impacts of HIV/AIDS on the workforce.

No clear health care assessment can be made without first understanding the present situation of service provision and identifying the human resource needs at each level – for training as well as for strengthening management capacity. For example, ministries of health with low budgets are often faced with the task of coordinating large numbers of NGOs, all of which need to be brought towards a common vision of national health development goals. To help fill the knowledge gap on service delivery, the WHO’s Human Resources for Health programme has developed surveys and instruments, made country visits, sponsored international workshops and steered development of the WHO capacity-building strategy.

Country visits to ART services have covered many aspects: the national human resources planning process, country approaches to ART training, organization of access to and funding for care, the role of community organizations, services rendered by different providers, task distribution and patient flow patterns. There is much variation among countries, largely because health care and responsibilities are defined differently in each.

One of the many issues identified is the emerging distribution of tasks and providers in the care cycle. Staff should be deployed in the most time- and cost-effective way possible. For example, in several settings it was found that in a stable patient community, adherence counselling and psycho-social support could be transferred to the community of people living with HIV/AIDS. The question each time is, “How can we maximize skills transfer within a framework of quality care so that the staff who have the highest level of clinical knowledge can be freed from other tasks and concentrate on the application of their knowledge to the largest number possible?”

Some key operational action points need to be addressed in order to provide ART at all levels of care:

- training of all health professionals to administer elements of ART,
- enhancing community participation and partnership,
- improving staff conditions and incentives (though fiscal constraints and public service regulations can complicate the reform of salary systems for incentive purposes),
- addressing the stigma among health workers towards HIV/ART where it exists,

- developing guidelines by which to manage international/donor inputs into strengthening human resources and service delivery,
- integrating operations research into the ongoing monitoring and evaluation of services.

In conclusion, bold decisions need to be taken based on a health systems approach, which takes into account all health actions, all actors and all stakeholders. If this is done with willingness and openness, the "3 by 5" drive is likely to speed the scale-up process tremendously.

3.4 Human Rights Related to Access to AVT
Jantien Jacobi, UNAIDS

The WHO and the Joint United Nations Programme on HIV/AIDS (UNAIDS) launched the "3 by 5" initiative on 1/12/03. At that time access to treatment was one of the key missing aspects in comprehensive care. Centres of excellence had shown that it was possible to provide treatment, and successful efforts were being made to reduce drug prices and introduce generics. Gradually countries have moved towards national treatment targets, and all partners at the country level have been integrated in the planning. The "3 Ones" are also being promoted in development thinking. These are principles for the coordination of national AIDS responses:

- 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 multi-sectoral mandate;
- one agreed country-level monitoring and evaluation system.

Since the kick off of "3 by 5", partnerships have been promoted and monitoring, planning and evaluation have been used to alert partners of critical issues. Efforts are now being made to scale up treatment and bolster prevention.

Bringing human rights into the equation
Human rights are internationally agreed principles and norms on the protection and promotion of individuals' rights, freedoms and dignity. Though human rights are challenged by realities on the ground, states are obligated to respect, protect and fulfil them. Public health policy seeks to protect the well-being of society as a whole, by influencing the social factors that impact on health. "Equity" refers to fairness (which relates to ethics) and "equality" refers to equal opportunity for all.

Many human rights are related to responses to the HIV/AIDS epidemic. The following can be said on the practical application of human rights in dealing with HIV/AIDS:

- There is general consensus on the centrality of the moral and legal value of human rights in the HIV/AIDS response.
- The human rights-based approach is often blamed for the inadequateness of strategies to combat HIV/AIDS.
- The human rights-based approach is interpreted differently by different organizations.
- The United Nations is currently developing a common understanding of the human rights-based approach.

Are human rights and public health conflicting approaches?

- Public health strategies may be in conflict with or indirectly undermine the promotion and protection of individual human rights (e.g., isolating people

who are HIV positive). Activism is needed, because human rights are not yet protected on a large scale and countries are apparently going through the same learning curve.
- Failure to protect human rights can be a driver of the HIV epidemic (as compulsory testing and social stigma may discourage those infected from coming forward).
- Protection of human rights supports effective public health outcomes.
- A human rights-based approach to public health is therefore vital for addressing the underlying conditions that make people vulnerable to HIV infection.

A human rights-based approach to testing and counselling would include a number of elements:
- an ethical process for testing;
- protocols by which the implications of a positive test result can be addressed;
- a supportive legal/policy framework within which the response can be scaled up;
- an adequate health care infrastructure, with all voluntary counselling and testing linked to treatment, care and other services.

How will the "3 by 5" initiative impact on human rights?
In 2002 access to prevention, treatment, care and support was revised building on five key premises:
- Access to HIV-related treatment is fundamental to realize the right to health.
- Prevention, treatment, care and support are a continuum.
- Access to medication is one element of comprehensive treatment, care and support.
- Ensuring sustainable access to medication requires action on numerous fronts.
- International cooperation is vital in realizing equitable access to care, treatment and support for all those in need.

Country experiences
- In general there is ongoing violation of human rights and significant difficulties in applying international laws.
- Civil society has claimed treatment to be a human right, yet the goal of treatment for all can only be realized progressively, because of the difficulty in accomplishing this huge task (e.g., treatment of children can be especially problematic).
- Shifts in funds pose a real threat to programmes focused on other health problems.
- It is assumed that health systems will be strengthened through "3 by 5", but this has yet to be demonstrated. There have been positive attempts and successes.

What can you do?
- Civil society has an important role to play, as the process needs human rights watchdogs.
- Monitors are also required for the scaling up of treatment and prevention measures.
- Advocates are needed to promote transparent processes that involve the public in reaching acceptable prioritization and progressive realization.
- Monitors are required in the development and implementation of strategic plans.

- Support is needed for capacity building among duty bearers and those claiming rights, as well as for people living with AIDS and the affected communities. UNAIDS has to act strategically with governments, since it cannot fulfil all roles. Empowered HIV-positive people and other members of civil society can and should take part.
- Finally, advocates are needed to involve and protect vulnerable populations.

4 Reports of the Meeting's Four "Focal Workshops"

4.1 Workshop on Logistics and Infrastructure

Roles in strengthening the "3 by 5" initiative
In the South, the Dutch could provide support for the "3 by 5" initiative in politically neutral areas and provide finance to organizations that can make noise. The current feeling is that the Dutch government contributes money but is not interested in influencing politics. Nonetheless, there are positive examples, such as in Bolivia and Uganda. In the North, the Dutch government could better leverage its political power, to become proactive in the way it positions itself on international boards. The Dutch contribute a large amount of finance, so they could have a lot of say, and they do have a lot of good things to say.

Dutch NGOs could take two parallel roles to strengthen the "3 by 5" initiative. First, in the South their emphasis should be on self-education, partner education, political noise and technical support. Second, within the Netherlands, they should work to manufacture consensus on the urgency of government-NGO collaboration. One idea is to identify sceptics who could be convinced. Co-financing institutions, as well as organizations such as Stop AIDS Now! and the United Kingdom's DFID could be partners in this process. An often-mentioned problem is NGOs' resistance to the medicalization of the HIV/AIDS epidemic. NGOs want to talk about prevention, but have less to contribute with regards to treatment.

Both government and NGOs should be careful when considering setting up parallel systems in the South. Good procurement, for example, does not necessarily require a parallel system. Countries presently have some flexibility in that they can hire procurement systems. The WHO offers technical support for countries to write procurement plans, but there is still too little money and too much involvement of political classes and elites. Procurement agencies can be contracted to do the job immediately, but at the same time capacity of the central medical stores should be built.

Question on reticence
If you decide to send people for a two-year training, you should be sure the anti-retrovirals are coming. Needs analyses are very country-specific and can even be specific to a regional system.

Question on the need for help, and the problem that local and national efforts have not been taken into account in the global plans, while in many countries civil society is taking its own initiatives. People from the South often do not want to be "advocated" for, they want to participate.
Problems have arisen in two-thirds of the countries where the Global Fund is working. People do not understand how to apply for the forms, etc.

Additional remarks from Jantine Jacobi of UNAIDS
There is support from UNAIDS and international development assistance for formulating and strengthening procurement plans. Governments should advocate for the "3 Ones" in the procurement and management of supplies. That would do a lot to harmonize procurement plans.

4.2 Workshop on Community Preparedness

The workshop on community preparedness looked at issues such as the effects of lifetime treatment at the personal level; experiences with adherence and compliance; impacts on communities (in terms of unequal allocation of resources and improved stability of the workforce); and community mobilization and expectations of and support for treatment/care.

A number of key considerations were identified in the implementation of AVT from a health system perspective:

- A multi-sectoral and multi-disciplinary approach is required.
- Access to treatment can help reduce stigma associated with HIV/AIDS.
- HIV/AIDS education programmes must be developed with a broad perspective, including sexual and reproductive health as well as treatment.
- Prevention, treatment and care must be integrated.

Roles to strengthen the "3 by 5" initiative
Roles of development organizations in strengthening the "3 by 5" initiative should include the following:

- supporting human resources;
- providing technical assistance, capacity building and assistance in forming strategic alliances;
- performing advocacy so that money trickles down;
- ensuring that money gets to where it is needed, through financial support to community-based organizations.

The Dutch government could play a number of key roles in strengthening "3 by 5":

- debt cancellation;
- supporting research/providing funds for better collaboration between research institutions in the North and South;
- facilitating freedom to travel;
- promoting integration of sexual and reproductive health and AIDS programmes, at the policy level and in practice;
- moreover, ACTION = IMPLEMENTATION!

Additional remarks from Marcel van Soest of the World AIDS Campaign
Medicines Sans Frontier, as one of the players on the ground, has learned that a programme can only be made to work by really investing in the community and supporting it at the pilot level. The question we may ask is why co-financing organizations – and other organizations – do not step in and support these groups? Where are they? Referring back to the Malawi example mentioned earlier, most co-financing organizations have been present in that country for many years. We must wonder why, instead of identifying gaps in the Medicines Sans Frontier approach, they do not hook up and strengthen the community involvement around the scaling up of this programme. Together they could show the added value of joint cooperation, with perfect synergism of an emergency scale-up approach and strengthening the systems around it – to guarantee sustainability.

4.3 Workshop on Human Resources

The workshop first listed some key considerations regarding human resources:

- Do not allow further depletion of the workforce. Use a comprehensive district approach and rational allocation of resources to counter this.
- Improved coordination could alleviate some of the pressure at the country level. The "3 Ones" should be applied at the country level but be recognized globally.
- There is a need for bold civil service reform to overcome staffing problems.
- The human resource crisis has been largely caused by structural adjustment programmes. The human resource gap can be filled only by increasing the workforce, and to do this we must explore alternative sources of health care workers from other sectors (though the mistakes of the traditional birth attendants programmes should not be repeated). Simplifying training curricula and stopping migration could help rejuvenate workforces. There is currently an enormous brain drain to western countries. Some training institutes in the South do not retain even 10% of their trainees for their own country. The United Kingdom has developed an "ethical recruitment policy" to discourage British employers from recruiting professionals from Africa; but not all agencies in the country adhere to it. The developing countries have thus become the victim of poor human resource planning in the industrialized countries.

Possible roles to strengthen the "3 by 5" initiative
The Dutch government could play a number of roles in strengthening the "3 by 5" initiative:

- raising its voice internationally for harmonization of procedures, improved coordination at the global level and for realizing the "3 Ones" at the country level;
- reviewing/reactivating the provision of technical assistance and collaboration, both North-South and South-South;
- acting to reduce international migration and developing and adhering to ethical recruitment policies;
- investing in absorption capacity of NGOs.

Remarks on the ethical recruitment policy:

- The United Kingdom's ethical recruiting policy originated from a collective request from the commonwealth group for a change in British employment tactics for teachers and nurses from the South.
- Although the United Kingdom developed the ethical recruitment policy, they do not appear to adhere fully to it themselves.
- The recruitment policy is two-way. It addresses not only the recruiting of human resources from developing countries, but also improving conditions for professionals in the South.

4.4 Workshop on Human Rights

The workshop listed some key considerations regarding human rights and the implementation of the "3 by 5" initiative:

- There is a need to reduce stigma and discrimination by health care workers.
- Education on sexuality has proven an effective response to the HIV/AIDS crisis. Sexuality should be put back into discussions on HIV/AIDS.

- The “3 by 5” initiative is bringing in the missing element of treatment, but it should be a comprehensive approach to all human rights, including the right to accurate information and education, reproductive rights and the right to care.
- Everyone should have equal access to treatment, including sex workers, intravenous drug users and prison inmates. Governments should be held accountable for equitable access. Monitoring could be done by NGOs (at different levels, e.g., advocacy, legal, cultural).
- The watchdog function of NGOs needs to be strengthened, building on the capacity of rights-claimers. NGOs and organizations of people living with HIV/AIDS should be enabled and supported.

Possible roles to strengthen the “3 by 5” initiative
Two main roles can be envisaged for the Dutch government in strengthening the human rights aspects of the “3 by 5” initiative:

- The Dutch government, together with other institutions of the European Union, could complement the initiatives of the US Agency for International Development (USAID). The Dutch, and Europe, should be more outspoken in advocacy and support for the most vulnerable groups.
- The Dutch government can assist in the harmonization, coordination and implementation of the “3 Ones”.

Tasks and challenges for NGOs in the Netherlands and in developing countries can also be enumerated:

- Be country-specific. Dutch organizations need to be culturally sensitive, which means different approaches are required from country to country.
- Advocate coordinated efforts and harmonized approaches (such as the “3 Ones”).
- Use Share-Net, as it offers an ideal platform for joint statements and for ensuring that problems are addressed strategically and proactively. Activism is not only useful for achieving a specific purpose. With the right connections, parliamentarians, co-financing organizations and governments can be influenced through cooperation, harmonization and networking.
- Ensure that the voices of those infected are heard. This includes people living with HIV/AIDS advocating for vulnerable and marginalized groups.
- A suggestion for the theme for the next meeting is “3 by 5” and poverty reduction.

5 Closure of the Meeting by the Chair

Many valid contributions were made today. There were strong overlaps in the presentations and discussions. There are technical issues; there are political issues; there are human rights issues. We cannot reach conclusions in such a short time, but there is no time to lose.

This was the first of a series of meetings. We have learned many things about how “3 by 5” functions – and how it does not function. We clearly need more discussion amongst ourselves and, for this, the next meetings will soon be planned. All participants and speakers are warmly thanked for their contributions.

Annex I Programme

9.30	Registration and coffee	
10.00	Introduction by day chair	Jan Dik, Health Planning Consultant
10.10	Opening	Catherine Hodgkin, Director KIT DEV
10.25	General introduction	Pieter Streefland, Senior Advisor, KIT
11.00	Kenya case	Marcel van Soest, Director, World AIDS Campaign
11.40	Coffee	
12.00	Medicines Sans Frontier case	Pierre Humblet, AIDS Advisor, Medicines Sans Frontier
12.30	Discussion	Referents and all participants
13.10	Lunch	
14.00	Logistics and infrastructure	Guido Bakker, Director, World Response
14.10	Human resources	Norbert Dreesch, Technical Officer, Department of Human Resources for Health, WHO
14.20	Community preparedness	Morolake Nwagwu, Coordinator Treatment Action Movement, Nigeria
14.30	Equity and human rights	Jantien Jacobi, Senior Advisor, Country Support for Care and Treatment, UNAIDS

14.45 Workshops on the four dimensions

1: Logistics and infrastructure	Guido Bakker
2: Community preparedness	Morolake Nwagwu
3: Human resources	Norbert Dreesch
4: Equity and human rights	Jantien Jacobi

15.45	Coffee	
16.00	Debate	
16.45	Closing remarks and wrap up	Day Chair, Jan Dik

Liesbeth Meuwissen – Rapporteur

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The Royal Tropical Institute (KIT) is an independent centre of knowledge and expertise in the areas of international and intercultural cooperation. The aims of KIT are to contribute to sustainable development, poverty alleviation, and cultural preservation and exchange. Within the Netherlands, it seeks to promote interest in and support for these issues. The department Development Policy and Practice conducts research, training and advisory services in four main areas: health, education, sustainable economic development and social development, and gender equity. The focus is on programmes that reflect both the knowledge specialty of KIT's professional staff and the priorities of developing countries. KIT is a not-for-profit organization. **Contact person**: Stephanie Bleeker, s.bleeker@kit.nl

The **Aids Fonds** was established in the Netherlands in 1985 and is active in the fight against AIDS and in supporting people with HIV/AIDS. The Aids Fonds obtains its resources from its own fundraising activities with contributions from the Dutch Ministry of Health, Welfare and Sport. In addition to raising and allocating financial resources, the Aids Fonds informs and serves the public on issues related to HIV/AIDS, looks after the interests of people with HIV/AIDS and creates a favourable climate for the ongoing fight against AIDS. The Aids Fonds works together with numerous organizations, researchers, government authorities and interest groups.
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Share-Net is a network of 30 Netherlands-based organizations and experts working in the field of sexual and reproductive health and AIDS. Share-Net seeks to contribute to improving the international sexual and reproductive health and rights situation as well as the HIV/AIDS condition, guided by principles of human rights, equity, equality and empowerment. Share-Net is involved in capacity building, information exchange and lobbying/advocacy. **Contact person**: Rachel Ploem, r.ploem@kit.nl.