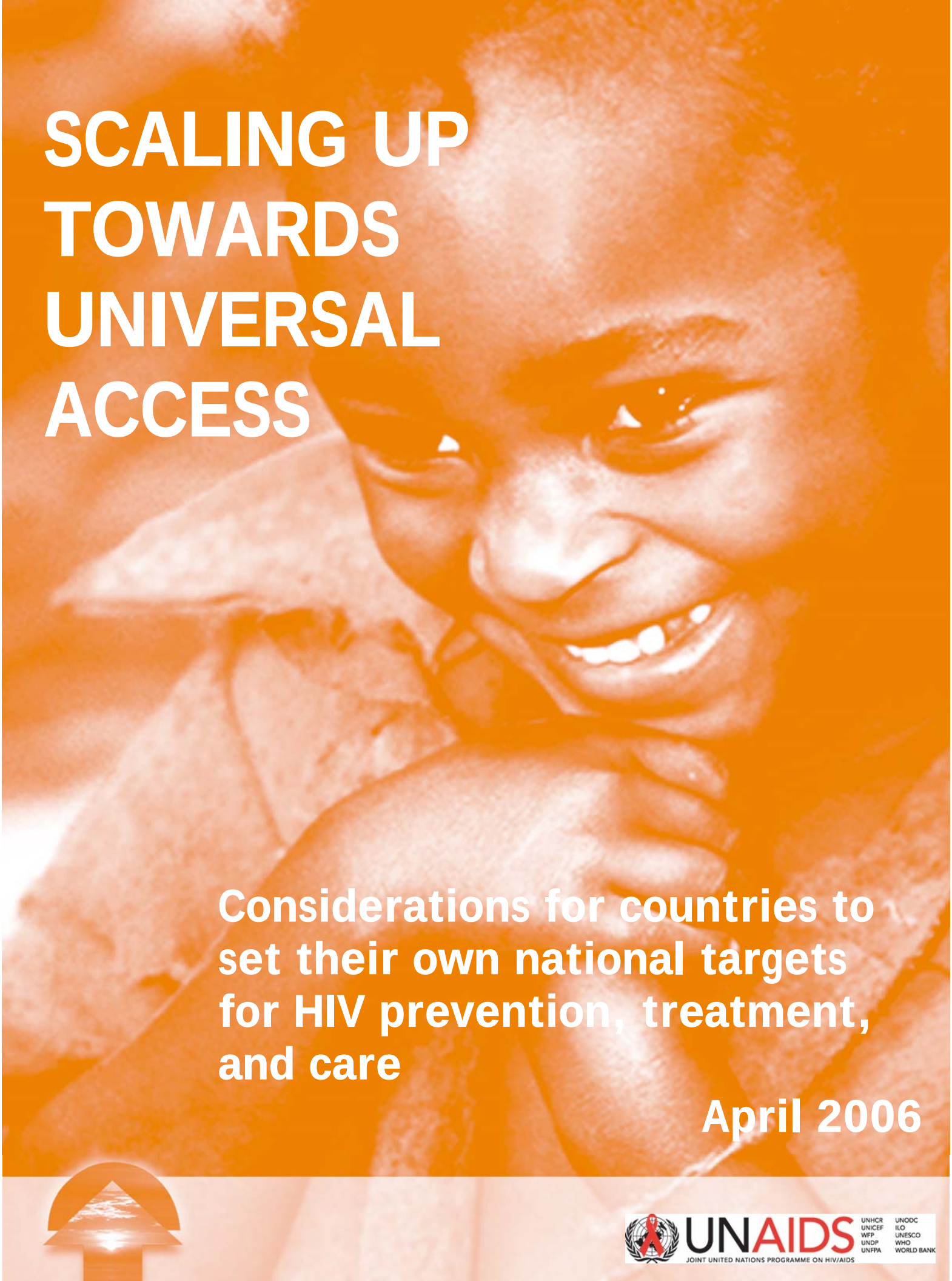

SCALING UP TOWARDS UNIVERSAL ACCESS

Considerations for countries to set their own national targets for HIV prevention, treatment, and care

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UNAIDS
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Scaling up towards universal access: Considerations for countries to set their own targets for AIDS prevention, treatment, and care.

BACKGROUND

Over the past year, a momentum has been building to dramatically scale up the response to AIDS, to define what this means for country programmes, and to address the obstacles that have prevented this from happening in the past. The Gleneagles G8 meeting and the UN General Assembly refer to scaling up AIDS prevention, treatment, care and support and to the concept of moving towards universal access.

"Requests ... that the UNAIDS Secretariat and its Cosponsors assist in facilitating inclusive, country-driven processes ...for scaling up HIV prevention, treatment, care and support, with the aim of coming as close as possible to the goal of universal access to treatment by 2010"
United Nations General Assembly resolution A/60/L.43 (23 December 2005)

"We commit ourselves, with the aim of an AIDS-free generation in Africa, to significantly reducing HIV infections and working with WHO, UNAIDS and other international bodies to develop and implement a package for HIV prevention, treatment and care, with the aim of as close as possible to universal access to treatment for all those who need it by 2010....."
G8 Leaders Communiqué, 8 July 2005

THE ROLE OF NATIONAL TARGETS IN ADVANCING TOWARDS UNIVERSAL ACCESS

The commitment to scaling up towards universal access (UA) is not a target itself. Rather it emphasizes urgency, quality and equity, and involves the development of a comprehensive package of prevention, treatment, care and support relevant to each country. In such a context, the use of specific targets can help countries define and prioritize their efforts in relation to coming as close as possible to universal access by 2010.

At the first meeting of the Global Steering Committee[1] the Working Group on Targets recommended **that no new global targets would be set at global level**. National governments and stakeholders would be encouraged to identify a small set of national targets for moving towards universal access, which build on, strengthen and expand national strategic plans. These targets would need to be incorporated in the national measurement strategy to monitor progress.

National targets can play a critical role in helping to establish strategic priorities, focusing efforts to monitor and evaluate programmes and mobilizing resources, towards universal access. They can also provide clarity on what has been agreed in terms of content and quality and therefore help to promote accountability. They provide a yardstick for monitoring action and results, including progress achieved and barriers encountered. They can positively raise expectations and become a focus for advocacy-both on behalf of the potential users of services and those responsible for reaching the defined targets to strengthen advocacy, mobilize resources, establish strategic priorities, and to focus monitoring programmes. There is also good evidence that the right targets can improve and focus the work of governments, donors and international organisations, e.g., the World Bank, UNICEF, WHO and UNAIDS at large.

Given the complexity of scaling up a comprehensive response to HIV/AIDS and moving towards universal access, countries may require assistance to assess and formulate a limited set of targets and to track them. A preliminary set of guiding principles can help countries.

[1] Global Steering Committee on scaling up towards universal access, 9-10 January 2006, Washington, USA

PRINCIPLES FOR ESTABLISHING TARGETS FOR SCALING UP TOWARDS UNIVERSAL ACCESS

What does "as close as possible to universal access" mean?

It is important to remember that there are many, very diverse definitions for the term, "universal access." Provision of services to all who need them is an extremely ambitious goal, which has seldom if ever been achieved even in high income countries. Each country must decide for itself what sustainable quality HIV/AIDS services they can achieve in this stated time period. If the perception and targets of what can be achieved by 2010 is unrealistic, then the credibility of the process can be diminished and the process as a whole can be undermined.

Build on existing goals, targets and national AIDS strategies.

The identification of any additional targets that reflect the concept of moving towards universal access should build and reinforce the existing targets that were established for the Millennium Development Goals and for the UNGASS Declaration of Commitment. See Annex II for Summary of existing global targets. These targets should ultimately measure progress toward the 2015 MDG goals. Any process to reaffirm existing targets or to establish new targets should involve key stakeholders within government and civil society.

The movement to scale up towards universal access should address needs and rights in terms of health, nondiscrimination and gender equality

Targets to scale up towards universal access should be designed to increase access to HIV prevention, treatment and care for those in need based on the specific nature of the epidemic in the country. For example, in countries with more generalized epidemics, where women and young girls are being infected at the fastest rate, targets should recognize their increased need for services. In low prevalence or concentrated epidemics, targets should be based on the populations most at risk of HIV exposure, such as injecting drug users, those involved in sex work and their clients, or men having sex with men.

The movement to scale up towards universal access should address the concept of coverage, defined as access, uptake and sustained use.

Many assume that "universal access" means 100% coverage of services. This is not necessarily the case. First, "coverage" in the sense of access implies increasing the offer of services to people in need, but this is not the ultimate goal. The increased uptake and sustained use services is the ultimate goal. However, some people will be offered services (e.g. testing and treatment) but will not choose them. This is particularly true where stigma, discrimination and violence against women are common. In the area of antiretroviral

treatment, for example, WHO currently bases its estimate of resource needs for universal access to antiretroviral treatment on coverage of 80%, on the grounds that this is the highest coverage achieved in high-income countries. Universal coverage of 100% is generally not feasible for ART, because some persons will not desire to be tested for HIV infection and, even if found to be positive, not everyone will decide it is the right time to start treatment. Access, uptake and sustained use of some interventions are easier to estimate and track than others. It is relatively simple to keep track of the numbers of people enrolled in national antiretroviral treatment programmes. It is more difficult—and arguably more important—to track the number of patients adhering to antiretroviral treatment. It is more difficult still to quantify access to prevention services and track progress towards universal access.

The movement to scale up towards universal access should address participation, quality, affordability, accessibility and equity.

Targets that encourage quality, full accessibility, participation of affected groups, as well as equitable delivery and uptake should be developed. These can include making condoms, comprehensive prevention information and testing more widely available; reaching women and young people, rural and minority populations; ensuring sufficient human resources; and ensuring consultative processes among those affected and the active involvement of people living with HIV. To the degree possible, data should be disaggregated by sex, marital status, age, income, ethnic background and rural/urban status.

The goal of moving towards universal access is only meaningful to the extent to which access is measured across different populations – ensuring that access to prevention, treatment and care is available for those least advantaged and socially marginalized

To evaluate successes in scaling up to universal access, monitoring and evaluation data must be disaggregated to describe not only gender and age, but also other relevant parameters, including urban/rural, risk populations, migrants, etc. Disaggregated data should be shared with civil society and donors as part of an annual review process. Disaggregated data provides the ability for validation of the data and to the understanding of the bottlenecks towards achieving universal access.

Targets for other key stakeholders

UNAIDS and key partners will also consider possible targets that could be established for global and national partners in industry, the UN, bilateral donors, and civil society.

GUIDANCE FOR COUNTRIES TO DETERMINE NATIONAL TARGETS FOR MOVING TOWARDS UNIVERSAL ACCESS

Targets are more powerful as a catalyst for increased action if they are

1. **limited in number,**
2. **very carefully considered as far as feasibility, and then**
3. **actively promoted.**

⇒ Targets should be used to mobilize increased resources and to inspire increased effort, but be realistic on what can be achieved.

⇒ Targets should reflect priority activities for the national programme, based on assessment of key modes of transmission and vulnerable populations. For example, in low prevalence or concentrated epidemics, targets should be based on the populations most at risk, e.g. injecting drug users.

⇒ The setting and monitoring of targets must include full participation by PLWH and civil society.

⇒ Measuring of targets for services should include both the public and private sector.

⇒ Generally, the concept of scaling up towards universal access is based on three critical elements: defining what interventions are to be included in programme implementation; what levels of coverage are to be achieved based on the populations in need; and the proposed target dates for achieving these levels of coverage. Specifically, coverage should be clearly specified in terms of service availability, uptake and sustained use (in the case of ongoing needs such as treatment programmes)

⇒ Defining the target for coverage of a specific service, such as ART, should be based on a number of key parameters:

- estimating the size of the population in need
- knowledge about current baseline levels of coverage,
- the current rate of scale up of services,
- the potential increased rate of scale up if there are additional investments in human resources and infrastructure, and

- the rate of scale up appropriate to achieve an inspirational target.

⇒ Because the movement to scale up towards universal access is based on national commitment, equity, quality and participation, targets should be considered in those areas.

⇒ As the response to AIDS evolves, it will be necessary to incorporate additional interventions into programmes. This is particularly true as new technologies become available, such as a microbicide. Targets should then be considered that would address these new programmatic areas.

⇒ While a country can establish multiple indicators to measure progress, the setting of targets must catalyze an increased political and strategic response that can generate new resources in order to achieve the goal of universal access. The "3 X 5" target; for example; was made more persuasive and meaningful because it captured the concept of treatment in a single, clear message, rather than having multiple targets that described the diverse components of treatment.

⇒ Countries should set only one or two key targets for 2008 and 2010 for each of the three major programme areas: prevention, treatment, care and support. These could derive from existing targets or require the setting of new, additional targets.

⇒ Targets should focus on both achieving defined impact as well as overcoming critical obstacles to scaling up. The impact level targets would be set for 2010 with interim "process" targets for 2008.

⇒ Time bound process targets should address obstacles to scaling up towards universal access by 2010. Such an approach would focus on, for example, the development of costed country-based plans, unblocking certain obstacles (e.g. securing price reductions for second-line therapies) and inevitably build on the agreed Global Task Team (GTT) recommendations. [2] Defining interim targets for overcoming obstacles to scale up can be based on four broad obstacles to overall scale up of the national response:

1. Predictable financing and macroeconomic issues
2. Human resource and system constraints
3. Development of low-cost technologies and access to commodities
4. Human rights, gender equity, stigma and discrimination

⇒ The following table gives suggestions for process targets for 2008. These do not need to directly relate to 2010 targets but should reflect current understanding about the most critical obstacles that need to be overcome in order to move towards universal access.

[2] GTT Recommendations are available on the following website: http://data.unaids.org/Publications/IRC-pub06/JC1125-GlobalTaskTeamReport_en.pdf

POSSIBLE INDICATORS FOR "INTERIM" PROCESS TARGETS IN 2008 THAT FOCUS ON OVERCOMING OBSTACLES TO SCALING UP

Sites for Preventing mother to child transmission

⇒ Number of ANC sites and estimated capacity to provide PMTCT services

Sites for HIV testing and counseling

⇒ Number of VCT sites in country

⇒ Number of TB clinics, hospitals which have instituted provider initiated routine offer of HIV testing

⇒ Number of VCT sites in country that serve defined most at risk populations

Size of risk population

⇒ Estimation of size and locations of most at risk populations

Number of Health Care Facilities for provision of ART

⇒ Percentage of health care facilities with basic treatment services (clinical care, laboratory capacity, and sustainable pharmaceuticals supply)

Human Resource Needs are Estimated

⇒ Numbers of necessary health service staff (physicians, nurses, clinical officers, counsellors, lab technicians and pharmacists) have been estimated.

Estimating Resource Needs

⇒ Resource needs have been estimated to scale up to 2010 targets and goals.

Civil Society Participation in NAC

⇒ Percentage of members in National AIDS Coordinating body who represent sectors of civil society

⇒ Targets set for equitable access to key prevention, treatment, and care interventions for defined vulnerable populations

Reducing Stigma and Discrimination and Assuring Human Rights

⇒ A defined oversight structure to be established to monitor and report annually on the enforcement of policies to protect human rights, which includes the active and participation of PLWH and civil society.

NEXT STEPS

1. National targets for scaling up towards universal access should be finalized by end of 2006. These targets should be for 2008 ("process targets" as presented on page10) and 2010 (Outcome Targets) as presented on page 12.
2. Baseline values for these proposed national targets should be determined in 2006 in order to measure progress over the next four years.
3. Further technical guidelines on setting targets for specific programme activities will become available later this year.
4. In 2007, established country targets could also be used for possible global target setting in the future. They would provide the perspective from countries as to what is ambitious and what is feasible. This would facilitate ongoing global strategic planning and estimating resource needs.
5. In the Table (Annex I) a "core" set of established, standardized indicators has been provided that could measure progress towards universal access. In addition there are a set of "recommended" indicators that may be appropriate depending on the country context. These indicators could be used as a framework for countries to identify and establish their own targets for scaling up towards universal access. Besides the three programmatic areas (prevention, treatment, and care and support) a fourth programmatic area has been included. This fourth section focuses primarily on national commitment, participation, and equity of access and building of capacity.

SELECTION OF TARGETS BASED ON EXISTING INDICATORS

The following tables are presented as guidance for the selection of national targets for moving towards universal access. This information is already being collected in almost all countries, and therefore can serve to inform the selection of key targets for 2008 and 2010. Not every indicator requires a target. Targets are more powerful for advocacy and resource mobilization if they are limited in number and are used to capture the essential concept of prevention, treatment and care.

It is recommended that countries set no more than one or two targets for the primary programmatic areas. The total number for the complete, comprehensive programme should be between 3 and 6 targets.

TREATMENT

- **Core Indicator 1:**

Percentage of women, men and children with advanced HIV infection (i.e. who meet eligibility criteria) who are receiving antiretroviral combination therapy

- **Recommended Indicator:**

Percentage of adults and children on ART who are still alive 12 months after initiation of antiretroviral therapy

PREVENTION

- **Core Indicator 3:**

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

- **Core Indicator 4:**

Percentage of general population or "most at risk" populations who received an HIV test in the past 12 months and were informed of the results[3]

- **Core Indicator 5:**

Number of condoms distributed annually by public and private sector

- Core Indicator 6

Percentage of young men and women aged 15 to 24 who have had sex before age 15

Recommended Indicators:

Coverage of targeted prevention programmes in low prevalence countries [4]

Percentage of young people (15-24) or "at risk" group who correctly identify ways of preventing sexual transmission of HIV and reject major misconceptions (male/female)[5]

CARE AND SUPPORT

- **Core Indicator 2:**

Percentage of OVC (boy/girl) aged under 18 living in households whose household have received a basic external support package* (in caring for the child) (The support package could include food, education, health care, family/home and/or community support.)

NATIONAL COMMITMENT

- **Core Indicator 7:**

Amount of national funds disbursed by governments in low and middle income countries

- **Recommended Indicator:**

Implementation of the Three Ones (according to UNAIDS check list, including the involvement of civil society and other stakeholders)

[3] This target should cover testing in health facilities and in other locations.
[4] In concentrated epidemics, this indicator should be considered as "Core."
[5] Knowledge encompasses an understanding about the role of delaying sex, reducing partners, and use of condoms in preventing sexual transmission of HIV.

INTERNATIONAL INDICATORS

There was agreement that there also needs to be accountability for international stakeholders (multilateral organisations, bilateral donors, civil society and the private sector). Indicators appropriate for target setting by these international partners are currently being identified.

ANNEX 1: EXISTING GLOBAL TARGETS FROM UNGASS, UNICEF AND THE MDGS

SOURCE OF TARGET	TARGET BY 2005	TARGET BY 2010	TARGET BY 2015
Millennium Development Goal No. 6 Agreed Sept 2000 by 189 countries			Halt and begin to reverse the spread of HIV[1]
UNGASS Declaration of Commitment on HIV/AIDS Targets Agreed by all UN member states in June 2001 – 103 commitments which includes 30 time bound targets	**COVERAGE AND INPUT TARGETS**: 90% of youth have information, education, services and life-skills that enable them to reduce their vulnerability to HIV Infection Annual spending on combating the epidemic in low and middle income countries to reach between US$ 7 billion and US$ 10 billion	**COVERAGE AND INPUT TARGETS** 95% of youth have information, education, services and life-skills that enable them to reduce their vulnerability to HIV infection (1) 80% of pregnant women accessing antenatal care have information, counseling and other HIV prevention services available to them. (2) Increase the availability of and providing access for HIV-infected women and babies to effective treatment to reduce mother to child transmission of HIV, as well as through effective interventions for HIV infected women, including VCT, access to treatment, especially antiretroviral therapy, and where appropriate, breast milk substitutes and the provision of a continuum of care.	
	IMPACT TARGETS 25% reduction in HIV among young people 15 - 24 *in the most affected countries* 20% reduction of the proportion of infants infected with HIV	**IMPACT TARGETS** 25% reduction in HIV among young people 15 – 24 *globally* Reduce the proportion of infants infected with HIV by 50%	

UNITE For Children **UNITE Against AIDS**		Provide either antiretroviral treatment or co-trimaxazole to 80% of children in need. Reach 80% of children most in need with basic services	
'Three by Five' WHO/UNAIDS declared at UN GA Sept 2003	3 million receiving antiretroviral treatment		