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UBRAF thematic report: access to treatment

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Results

At the end of 2013, 35 million [33.2 – 37.2] people were estimated to be living with HIV and 12.9 million people living with HIV were receiving antiretroviral therapy (ART). AIDS deaths have decreased by 30%, and new infections declined by more than 20% during the period from 2006 to 2013. Globally, 37% of people living with HIV received ART; treatment scale-up averted an estimated 7 million deaths, and prevented 1.1 million new paediatrics infections between 2002 and 2013. Access to ART has increased in all regions, though with considerable regional and population variation. The greatest scale-up occurred in sub-Saharan Africa, which has the highest burden of HIV and is home to 70% of people receiving ART in 2013(71% of people with HIV live in this region). Treatment coverage remains low in the Middle East and North Africa and Eastern Europe and Central Asia and (less than 10% and 21% of people living with HIV, respectively). The percentage of children living with HIV who received ART in the 21 sub-Saharan African Global Plan priority countries increased from 14% in 2011 to 22% in 2013. This proportion is still much lower than the percentage of adults living with HIV who received ART and the global target to provide ART to all children in need by 2015 and emphasizes the necessity of making antiretroviral drugs (ARVs) available to all children under five years of age. Detailed data on treatment access among key populations is lacking, but limited data indicate coverage is lagging, and in many settings they remain key drivers of the epidemic.

1. WHO provides comprehensive guidelines for HIV response

WHO provided a comprehensive framework to guide national health sector responses and strategies for HIV diagnosis, treatment, care and prevention, and outlined priorities on implementation science research agendas, including specific work related to the strategic use of ARVs (Strategic Use of Antiretrovirals, or SUFA). This work focuses on two areas through a set of consolidated guidelines and implementation science priorities: providing guidance on the strategic use of ARVs, and optimizing HIV treatment scale-up through the Treatment 2.0/Innovations.

In June 2013, WHO launched the *Consolidated ARV guidelines on the use of antiretroviral drugs for treating and preventing HIV infection.* This publication includes 56 new clinical, operational and programmatic recommendations for adults, adolescents, children, and pregnant and breastfeeding women across the continuum of HIV care, and incorporates key existing guidance. The guidelines were informed by systematic evidence reviews, global consultations on values and preferences, mathematical modelling, impact and cost–effectiveness, and feasibility and implementation considerations. The new guidelines recommend treating more people at an earlier stage, including initiating treatment in all adults with HIV with CD4 count ≤500 cells/mm3, initiating ART in all pregnant and breastfeeding women, and initiating treatment in all children <5 years of age regardless of CD4 cell count or clinical stage. The document also recommends the use of more simplified and less toxic treatment options as fixed dose combinations and use of point of care diagnostic technologies. WHO worked with national ministries of health and in-country stakeholders to help countries adapt the guidelines to their own specific needs, conducting seven regional workshops between July and November 2013, covering 90 countries from all six WHO regions; nearly 90% of countries reported their intention to adopt new ARV eligibility recommendations.

UNICEF, WHO and the Elizabeth Glaser Pediatric AIDS Foundation (EGPAF) convened a ministerial meeting that endorsed a new action framework for improving the survival rates of HIV exposed, infected and uninfected infants. This Double Dividend Initiative is based on recent country-

level evidence reviews, including one on integrating HIV infant testing into immunization programmes in three countries in 2013, and a 2012 multi-country paediatric HIV assessments in four countries. UNICEF worked with WHO to revise community health worker tools for integrated community case management of sick children (iCCM) to better identify and provide care to HIV exposed or infected children.

2. UNDP provides financing, capacity development and training support

In 2012–2013, UNDP served as interim principal recipient for 32 Global Fund HIV grants in 25 countries that served 1.3 million people on treatment; approximately one in four of all treatments are financed through the Global Fund. In 2012, UNDP provided capacity development support to government officials from nine countries in Latin America and the Caribbean for using public health-related TRIPS flexibilities to increase treatment access. UNDP also organized training for government officials from five countries on the examination of pharmaceutical patents from a public health perspective and cosponsored a regional consultation and planning workshop on the use of TRIPS flexibilities and access to affordable ARVs in Asia in May 2013, which drew more than 90 participants from nine countries in Asia.

The ILO, with the Human Sciences Research Council of South Africa (HSRC) and WHO, reviewed the impact of employment status on ART adherence. The review found employment significantly contributes to HIV treatment adherence, with employed individuals 39% more likely to adhere to ART compared with those who are unemployed. The ILO will collaborate with WHO in 2014 to study factors that contribute to successful employment-related treatment programmes. The ILO and the National AIDS Secretariat of Sierra Leone examined the factors contributing to adherence rates among workers in the Sierra Rutile Limited workplace that were higher than national average for the elimination of mother to child transmission (eMTCT) and ART treatment. Results indicated confidentiality of status, continued employment and free medical treatment and services via the employee's health clinic, as well as accessible treatment services, including short waiting times, were key to treatment adherence.

3. Food and nutrition assistance; antiretroviral therapy for refugees

In 2013, the World Food Programme (WFP) provided food and nutrition assistance to malnourished people living with HIV on ART in 20 countries. In 10 of these countries, a household ration was also provided to minimize sharing of the individual ration among family members. In 2012, WFP reached 217 858 malnourished ART clients with food and nutrition assistance in 26 countries. In 16 of these countries, WFP also provided a household ration to 751 307 members of food-insecure households of malnourished ART clients. WFP has also collaborated with the Sydney-based Albion Street Centre, Australia's largest HIV ambulatory care centre, WHO, and UNAIDS to produce a manual, *Nutrition assessment, counselling and support (NACS) for adolescents and adults living with HIV: food and nutrition in the context of HIV and TB*, which will be published in 2014.

By the end of 2012, global access to ART for refugees was 93%. UNHCR provided ART to refugees while at the same time lobbying for their inclusion in national programmes. UNHCR reviewed adherence to ART and treatment outcomes among conflict-affected and displaced populations. The study highlighted that treatment strategies can be implemented in humanitarian crises; the range of optimal adherence was 87–99.5%. Following the release of the WHO consolidated guidelines in 2013, UNHCR, in collaboration with the South African HIV Clinicians Society, the Africa Centre for Migration, Médecins Sans Frontières Australia (MSF) and Save the Children, began the process of

adapting these guidelines for migrants (internal and international), as well as displaced populations, including refugees, asylum seekers and internally displaced persons in South Africa. These guidelines will increase global access to ARVs.

Constraints, challenges and lessons learned

Although ART scale-up continues and the UN global target to put 15 million on treatment by the end of 2015 is expected to be met, this scale-up has been variable across regions and unequal across the different populations, with lower coverage particularly among children, adolescents and key populations (men who have sex with men, sex workers, injecting drug users and transgender persons). Likewise, despite overall progress on treatment coverage and a reduction in HIV incidence at the global level, certain regions are lagging behind. For example, ART coverage in the European region is only 36%, and a 3% increase in new HIV infections was observed since the previous year. Children with HIV continue to lag significantly behind adults in ART access, and age disaggregation for monitoring access and outcomes of paediatric ART remains a challenge. Evidence on the optimal models for scaled-up paediatric HIV care is minimal, and more work is needed to optimize models of care and quality service delivery in decentralized settings.

The full implementation of the 2013 ARV guidelines will reduce HIV mortality and new infections by half in the next decade, with an incremental cost of only 10% when compared with the full implementation cost of 2010 guidelines. In 2013 63% of people living with HIV were not receiving ART. To close this gap, it will be necessary to accelerate ART scale-up, improve the quality of treatment, make drugs and laboratory tests more accessible and affordable, and retain more people in care. ART services must be more efficient and effective if they are to be sustained.

Despite the recommendation to initiate ART earlier, patients continue to present late for care, including those in high-income countries, leading to avoidable mortality and morbidity, and additional cost to the health-care system. A normative package for managing late presenters is needed.

Quality programming and adherence to treatment requires efforts to adapt to the challenges of humanitarian crises. Human resources are often scarce and turnover high. Stigma and discrimination also complicates patient acceptance. Medical and nutritional services are often stretched, resulting in fewer people being reached. Some countries still do not include refugees and other persons of concern to UNHCR in their national programme.

Finally, while the number of people initiated on ART continues to rise, there continues to be substantial patient attrition across the cascade of care, from HIV testing to long-term adherence and viral suppression. Urgent work from Cosponsors is required to better support uptake, treatment adherence and retention across the continuum of care.

Key future interventions

WHO will document country experiences and progress towards adapting and implementing its consolidated guidelines on ARV. WHO will also develop a roadmap for updating these guidelines over the next five years (using Strategic Use of ARVs (SUFA) and Treatment 2.0 frameworks) and establish the clinical and implementation science agenda across the continuum and cascade of HIV treatment and care to support this roadmap. Through this roadmap, WHO will provide countries and regions with technical guidance on managing noncommunicable diseases among people living with HIV, long-term complications of ART among adults and children, HIV care for late presenters,

including guidance on ART, opportunistic infections and other co-morbidities associated with severe and advanced HIV disease.

WHO and other Cosponsors will continue to help expand testing and treatment for clinical and prevention benefits, focusing on children, adolescents, pregnant women and key populations. In most countries, efforts remain inadequate in reaching members of various key population groups with HIV prevention, treatment and care services.

UNICEF, WHO and the Elizabeth Glaser Pediatric AIDS Foundation will operationalize the Double Dividend action framework in selected countries, pilot HIV-adapted iCCM tools in two or three countries and gather further evidence and country support on early infant diagnosis integration into immunization services and in identifying bottlenecks in delivering paediatric HIV treatment and care.

UNDP will continue high-level policy dialogue for developing affordable optimized drug formulations and diagnostics, TRIPS flexibilities and reduced ARV and laboratory test pricing for middle-income countries. UNDP will prioritize support to countries aiming to achieve sustainable financing for HIV, tuberculosis and malaria programmes, especially urgent in middle-income countries and in high-burden countries. UNHCR, in collaboration with national HIV programmes, will increase community support for treatment adherence and pilot promising practices for monitoring and support systems.

Supporting documents

- *WHO. 2013. Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection.*
  http://www.who.int/hiv/pub/guidelines/arv2013/download/en/
- *2013 UNAIDS Report on the global AIDS epidemic*
  http://www.unaids.org/en/resources/publications/2013/name,85053,en.asp
- *WHO. 2012. Strategic use of antiretrovirals.*
  http://www.who.int/hiv/pub/strategic_use/en/
- *WHO, UNICEF, UNAIDS. 2013. Global update on HIV treatment 2013: Results, impact and opportunities.*
  http://www.who.int/hiv/pub/progressreports/update2013/en/
- *WHO, UNODC, UNAIDS. 2013. Technical guide: setting targets for universal access to HIV prevention treatment and care for IDUs.*
  http://www.who.int/hiv/pub/idu/targets_universal_access/en/
- *Technical guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users, 2012 revision;*
  http://www.who.int/hiv/pub/idu/targets_universal_access/en/index.html
- *Issue brief, TRIPS transition period extensions for least-developed countries.*
  http://www.undp.org/content/undp/en/home/librarypage/hiv-aids/-trips-transition-period-extensions-for-least-developed-countrie.html
- *Adherence to antiretroviral therapy and treatment outcomes among conflict-affected and forcibly displaced populations: a systematic review*
  http://www.conflictandhealth.com/content/6/1/9/abstract

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