

Reaffirming the G8 Commitment to Universal Access: Gleneagles + Five

In 2005, the Group of Eight (G8) nations meeting in Gleneagles, Scotland, made a historic commitment to universal access to HIV prevention, treatment, care and support by 2010 – a commitment that was subsequently reaffirmed by United Nations (UN) Member States.¹ Five years later, major donors and domestic governments appear to be pulling back on this commitment. While significant progress has been made toward expanding access to HIV prevention and treatment since 2005, the universal access goal is far from being met.

The IAS calls for a concerted global effort, led by the G8 nations, to significantly scale up access to HIV services, with the objective of reaching the universal access goal as soon as possible. Such a global effort requires renewed leadership and commitment by the G8 member states. In particular, it falls to the 2010 G8 host nation, Canada, to ensure that the commitment to universal access is prominent on the agenda of the upcoming G8 summit in Muskoka, Canada.

The IAS also calls on the Group of Twenty (G-20) Finance Ministers and Central Bank Governors – which will convene at the Muskoka Summit as well – to assert its leadership in support of the G8 in a scaled-up global effort to achieve universal access. The G20 is made up of the finance ministers and central bank governors of 19 countries and the European Union.

Where Are We Today on Universal Access to HIV Treatment and Prevention?

UNAIDS calculates that for every two people who first accessed treatment in 2007, five became newly infected with HIV in the same period. An estimated 5.5 million people with advanced HIV infection today have no access to antiretroviral therapy (ART). That number is expected to double when World Health Organization (WHO) guidelines are updated in late 2009 to recommend that people begin treatment at higher CD4 counts.^{2,3}

Progress towards universal HIV treatment also varies substantially between countries and regions. Globally some 43% of people in need of treatment are now accessing antiretrovirals, but the regional variation in ART coverage rates is substantial. For example, overall coverage for Sub-Saharan Africa is 44%, while coverage rates in Eastern Europe and Central Asia are far lower, at 22%. Rates in North Africa and the Middle East, at 14%, are lowest of all.

¹ The definition of universal access varies but is generally agreed to mean that 80% of more of people in need are accessing a given service or intervention (this is because even where services are universally provided it is unusual for more than 80% of people to use them).

² WHO, UNAIDS, UNICEF. Towards Universal Access: Scaling up priority HIV/AIDS interventions in the health sector, Progress Report September 2009. Available at: <http://www.who.int/hiv/pub/2009progressreport/en/index.html>

³ The figure on the number of people who need, but do not have access to, treatment is calculated using current WHO guidelines. This number is expected to increase substantially if and when the guidelines are revised to recommend earlier initiation of ART, which is now standard practice in wealthier countries.

Globally, access to HIV prevention has increased substantially since 2005. Progress in many areas is complicated, however, by the continued reluctance of many governments to make use of the full range of proven HIV prevention tools, and to target interventions to the most affected populations. Substantial gaps in coverage persist, especially among the populations in greatest need of HIV prevention interventions, including people who inject drugs, men who have sex with men and sex workers.

Prevention and treatment must be scaled up in tandem. Treatment is an essential and synergistic component of the strategy to curb HIV infections, as treatment reduces HIV viral load and the likelihood of transmitting HIV. Treatment availability also increases uptake of other HIV services, and HIV testing to access treatment services can influence prevention decisions. At the same time, scaling up treatment programmes without investing in prevention is shortsighted and economically unsustainable. The tide of new HIV infections must be significantly reduced in order to make long-term, sustainable universal access to HIV treatment a reality.

More Patients in Need Calls for Expanded Access Efforts

The effectiveness of ART has improved since the first commitments to universal access were adopted in 2005. Newer HIV treatment regimens are safer and simpler to use, and second- and third-line therapy regimens are now available for patients whose initial treatments have failed. These advanced therapies can extend life expectancy. If made available in a timely manner to those in need, the therapeutic benefit of ART will extend for decades. New WHO guidelines – likely to be issued in the next few weeks – are expected to endorse making more advanced HIV treatment regimens available throughout the world. Due to their higher costs, however, these regimens remain largely beyond the reach of people living with HIV in low-income countries.

Current WHO guidelines call for the initiation of ART at 200/mm³ CD4 cells or fewer. The new guidelines are expected to recommend initiation of treatment at a CD4 count of 350/mm³, resulting in a substantial increase to the number of people in need of lifesaving ART. While this increase in patients will represent a further challenge to achieving universal access, it also offers an opportunity to make a far more substantial impact on the epidemic, as providing ART to more patients in need will significantly reduce not only HIV-related morbidity and mortality, but also reduce the incidence of HIV and tuberculosis (TB).

A substantial body of new evidence gathered over the past five years supports earlier initiation of ART, which has been associated with improved survival and tolerability, decreased toxicity and better immune reconstitution. Earlier initiation of ART has also been shown to decrease the spread of HIV, and to prevent the spread of TB among HIV-infected and non-infected individuals. A recent modeling study by Granich et al. published 26 November 2008 in *The Lancet* demonstrates that nationwide annual HIV testing followed by immediate antiretroviral therapy for those who are HIV-positive, in combination with proven prevention approaches, could virtually eliminate HIV transmission within a decade.

Ample evidence shows that the most effective approach is “combination prevention”. A mix of behavioural, biomedical and structural HIV prevention approaches have been proven to be effective, but are still not implemented or supported at nearly the level required to reverse the epidemic. In addition to strategies to use ART to prevent vertical, sexual and blood-borne transmission of HIV, these proven interventions include needle and syringe exchanges, methadone maintenance and other harm reduction programmes for people who inject drugs; education and support for stigmatized communities including sex workers and men who have sex with men; efforts to support and empower women and girls; distribution of male and female condoms; voluntary counseling and testing; medical male circumcision; and efforts to reduce HIV stigma, which inhibits the uptake of lifesaving prevention services.

Effective prevention requires both significant financial support and political leadership to ensure that appropriate combinations of scientifically-proven HIV prevention services are available to all.

Where is the G8 on Their Commitment to Universal Access?

UNAIDS estimates that achieving universal access to HIV prevention, treatment, care and support will require US\$61 billion between 2008 and 2010, and that international donors will need to mobilize two-thirds of this total (approximately US\$40 billion). As the largest global economies, and in keeping with historic trends on funding public health and development efforts, the G8 nations (Canada, France, Germany, Italy, Japan, the UK, the US and the Russian Federation) should be expected to assume responsibility for at least 80% of the total amount contributed by international donors, or US\$32 billion. However, an analysis of G8 spending completed by the International AIDS Society (IAS) at the end of 2008 found that G8 member countries have only committed approximately US\$22.2 billion to the universal access effort. This represents about 69% of the amount needed from international donors as a whole, and just 36% of the total global amount needed to achieve universal access.⁴

The IAS applauds the Obama Administration for the recent US\$6.6 billion pledge through the US President's Plan for Emergency AIDS Relief (PEPFAR) – the single largest contribution to the global response to AIDS. While the “fair share” for countries to contribute to global AIDS spending is difficult to calculate, it is clear that if all G8 countries honoured the commitments made at the Gleneagles G8, the resource gap for AIDS would close dramatically.

However, the IAS is concerned that several G8 countries appear to have begun to shift their focus away from AIDS, reallocating resources more generally across a range of global health priorities. The global financial crisis has had a dampening effect on donor aid, and has also led some middle-income countries to reduce their domestic spending on AIDS – a substantial source of funding for AIDS.

With so many of the world's nations committed to scaling up programmes to achieve universal access, demand from countries for resources from the Global Fund to Fight AIDS, Tuberculosis and Malaria has also been significantly higher than anticipated in the last two years. The Global Fund Board has recently needed to impose cost-savings measures in order to meet this high-level demand. Amidst fears that it would be delayed, the Global Fund Board has just announced that its tenth call for proposals will be launched in May 2010. Leaders have called on donor nations to take urgent action to ensure that the Global Fund is able to meet current and future demand for funding.

In July, Médecins Sans Frontières reported that funding gaps and supply management problems have led to the delay, suspension or risk of suspension of the supply of HIV drugs in South Africa, Malawi, Uganda, DR Congo, Guinea and Zimbabwe. These “stock outs” mean that people with HIV have to interrupt their treatment, which may cause resistance, treatment failure, increased illness and early death.

⁴ The G8 does not currently have a clear, uniform reporting system to track commitments and spending, therefore, these numbers are estimates based on publicly available information and data. In addition, the UNAIDS estimate of spending needs assumes current treatment guidelines, and will increase when WHO changes this to recommend earlier treatment.

The Call for a Recommitment to Universal Access in 2010

With so much new evidence supporting the importance of achieving the universal access goal, the need for significant and reliable funding for AIDS has never been greater. Achieving universal access to HIV prevention, treatment, care and support will not simply curb AIDS-related morbidity and mortality, but also significantly decrease HIV transmission and the burden of TB in individuals infected and uninfected with HIV worldwide.

With 2010 fast approaching, the G8 members must act quickly to follow through on their commitment to universal access. The end of the HIV pandemic cannot be achieved if the G8 nations fail to meet the commitments they made at the 2005 Gleneagles Summit. Like all of us, they must be held accountable for keeping their promises on AIDS.

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