



# The "3 by 5" Target

TREAT THREE MILLION PEOPLE LIVING WITH HIV/AIDS BY 2005 – MAKE IT HAPPEN

The World Health Organization "3 by 5" newsletter attempts to provide a snapshot of information about activities going on around the world to increase access to HIV/AIDS treatment and prevention in line with the target to treat 3 million people living with HIV/AIDS by the end of 2005. Find out more about "3 by 5" and the ultimate goal of ensuring universal access to antiretroviral treatment for all who need it at [www.who.int/3by5](http://www.who.int/3by5)

## NEWS IN BRIEF

### Military can be 'role models' in the fight against AIDS

Militaries can play a model role in the fight against AIDS and can be part of the global solution, said experts at the first ever International Conference on HIV/AIDS and the Military held in Pune, India in September.

Military commanders and medical officers from 14 countries met at the conference, which was organized by the Director General of the Indian Armed Forces Medical Services and the US Pacific Command. It was held at the Armed Forces Medical College in Pune with the aim of devising a joint strategy to combat HIV/AIDS.

In a key-note address, Dr Randall Hyer, in charge of the Civil Military Liaison Activity in Communicable Diseases at WHO, stressed that militaries are "a force for good and part of the solution [to tackling the AIDS epidemic] lies in their leadership by being role models." Illustrating military successes in the fight against AIDS, Dr. Hyer pointed to the accomplishments of the Royal Thai Army which has implemented successful HIV/AIDS programmes within their ranks, and to the Indian armed forces who launched an AIDS control programme in 1992, which aims to change high-risk behaviour through information, education and communication, together with ART.

"Militaries have robust public health systems along with well-organized health delivery systems with broad coverage, excellent access, and follow-up that can serve as models in our common struggle against HIV/AIDS," he said, underlining how militaries can take action and help work towards the "3 by 5" target.

Reinforcing the call for action, guest speaker Lieutenant General B Takhar, General Officer in Charge of the Indian Southern Command, urged militaries to take the lead against AIDS. "Too often, the skills and expertise of highly-trained soldiers is being lost to AIDS," he said.

### Phuket Declaration on oral health in HIV/AIDS

Oral manifestations of HIV such as fungal mouth ulcers or acute gum disease are a growing disease burden for several regions of the world, particularly Africa and Asia. The WHO Oral Health Programme gives priority to initiatives that increase control of oral diseases in HIV-infected people and lead to improved quality of life.

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## IN FOCUS

### "3 by 5" Country Officer recruitment begins; more support needed

As part of the drive to reach the "3 by 5" target, WHO has recruited 19 international HIV/AIDS experts to provide direct technical support to countries around the world in increasing access to HIV/AIDS treatment and prevention programmes. This initial recruitment is part of a plan developed in June 2004 to strengthen WHO's presence in countries to help rapidly scale up programmes and overcome obstacles. Over the next few months, teams are being established to support 50 countries but this is still not enough. More support is necessary to assist countries with treatment and prevention activities.



WHO/Michael Jensen

Assessing the challenges at the field level: "3 by 5" Country Officers will provide direct assistance on the ground.

"Establishing country teams is critical to rapidly move national programmes ahead. Expertise needs to be readily available on the ground in countries. As countries implement their programmes, the need for more and more technical assistance is identified. These increasing requests demonstrate the need to strengthen both WHO's capacity in countries and the role of country partners in providing appropriate assistance. Urgent assistance is needed not only in the 50 countries that will be covered by new scale-up teams. We also need to respond to other developing and transitional countries that are struggling to increase access to programmes," said WHO's HIV/AIDS Country Support coordinator Dr Andrew Ball.

"3 by 5" Country Officers recruited during this first phase will cover 19 countries, across all six WHO regions, which are heavily burdened by HIV/AIDS: the Africa Region (Burkina Faso, Ethiopia, Kenya, Malawi, Mozambique, Nigeria, Swaziland, Uganda, United Republic of Tanzania, Zambia and Zimbabwe), the Americas (Haiti), the Eastern Mediterranean Region (Sudan), the European Region (Russian Federation, Ukraine), the South-East Asia Region (India, Myanmar), and the Western Pacific Region (Cambodia, People's Republic of China).

New "3 by 5" Country Officers have already started work in Cambodia, Russia and Ukraine. In addition, over the past few months, new staff have been recruited to support "3 by 5" activities in a number of other countries, including Azerbaijan and Uzbekistan.

Dr Arielle Braye, a recently recruited "3 by 5" Country Officer for Ukraine, says having technical officers within countries is the best way to identify needs and to coordinate partner roles.



Arielle Braye, "3 by 5" Country Officer for Ukraine

"We need to work in an extremely coordinated way and this work has to be done in countries, where we have a much closer and more accurate view of the needs and problems faced in the different sectors," she said.

"We can put theory into practice. We have a host of excellent tools at our disposal like technical guidelines and the AIDS Medicines and Diagnostics Service (AMDS) that we can bring together for action. Being in the country allows us to better channel our energies into the areas where WHO technical assistance is most urgently needed," she added.

In late October, all the new staff met in Johannesburg for the "3 by 5" Country Officer Induction training programme. The workshop brought the new Country Officers together with other WHO staff (from countries, regional offices and headquarters) and partners in a team-building, orientation and skills-building programme.

"This training was an excellent time for reflection. We were able to exchange our experiences and the problems we are facing as well as solutions to these problems that have been applied successfully in similar settings," said Dr Braye.

The second phase of recruitment for additional staff will begin within the next few months as additional funds become available.

"We want to do more and be able to satisfy all the requests for assistance we receive. We need to recruit more people and we urgently need the money to make it happen," said WHO's Dr Andrew Ball.



## Central American nations make progress and confirm commitment to universal access target

Countries from the Central Americas sub-region are reporting progress in the estimated number of people receiving ART.

At a meeting held in Costa Rica at the end of August, countries reported that in Honduras the number of people on ART has increased from 183 in 2002 to 2312 in 2004, while in Panama it has increased from 1147 (2002) to 1873 (2004), and in Guatemala it has almost doubled in the last year alone (from 1222 in 2003 and 2227 in 2004).

Countries from seven nations—Belize, Costa Rica, El Salvador, Guatemala, Honduras, Nicaragua and Panama—met to underline progress towards the goal of achieving universal access to treatment for people who need it by the end of 2005, which was set in January 2004, marking the region's contribution to "3 by 5".

Progress analysis showed that nearly 50% of the countries have a fully developed coordination mechanism for purchase of drugs and other supplies, clear guidelines for distribution of drugs and supplies and a mechanism to monitor adherence. Over 70% of the countries have resident professionals familiar with drug regulatory framework and quality criteria and have guides and education for health workers involved in ART services.



The Americas region has set a target to provide 100% access to ART by 2005. Here, a patient in Haiti shows the effects of ART after only three months.

ART, development of financial systems to implement comprehensive care plans and support in assuring the uninterrupted procurement and supply of high-quality drugs and other commodities.

The Americas Region's groundbreaking target to provide 100% access to ART by 2005 was set in January 2004 at the Monterrey Summit of the Americas when presidents and prime ministers of 34 countries met in an unprecedented move to sign a commitment—the 'Nuevo León' Declaration—which pledges to treat at least 600 000 people living with HIV in all countries of the hemisphere, including Canada and the United States of America.

"Achieving 100% ART coverage in the Americas will require an extraordinary effort but the signs are extremely positive and the meeting in Costa Rica showed again how committed the region is to reaching the target to which they committed in the Nuevo León Declaration," said Dr Carol Vlassoff, Regional Adviser for HIV/AIDS, WHO Regional Office for the Americas.

## Virtual knowledge-sharing with the "e-3x5" forum

In the drive to increase access to HIV/AIDS treatment and prevention, many countries have considered new approaches to programming. While innovative policy and clinical guidelines have been launched to assist them, these were not reaching all practitioners in developing countries soon enough.



To bridge this information gap, the «e-3x5» Internet forum, hosted by Satelife, was born. Initiated by doctors, policy-planners, activists and staff at the WHO department of HIV/AIDS, the forum was set up to enable the sharing of thoughts and experiences on timely issues and emerging questions on treatment and prevention in different countries.

In the months following its inception, the forum now links over 600 specialists working on HIV/AIDS projects, including doctors, health policy-makers and NGO project officers from developed and developing countries, including HIV/AIDS heavy-burden countries in Africa. The forum uses the simplest technology to reach those with low Internet connectivity and it has become a platform for virtual knowledge-sharing around the world. Find out more about the «e-3x5» forum and sign up as a new member at <http://list.healthnet.org/mailman/listinfo/e-3x5>. Archived information can be accessed at <http://www.healthnet.org/>.

## NEWS IN BRIEF

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In July 2004, the 5th World Workshop on Oral Health and Disease in AIDS—co-sponsored by WHO—was held in Phuket, Thailand.

A commitment to action, the 'Phuket Declaration on oral health in HIV/AIDS 2004,' was fully endorsed by 27 participating countries, which encouraged national and international health authorities, dental associations and research institutions to strengthen their efforts towards the effective control of HIV/AIDS.

As part of the declaration, participants resolved to support the work carried out by national and international health authorities, research institutions, NGOs and civil society for the effective control of HIV/AIDS-related oral disease. In particular, the following areas of work should be strengthened:

- provision of systematic epidemiological information on oral health conditions associated with HIV infections;
- promotion of research into understanding oral disease related to HIV and identification of the most indicative oral manifestations of HIV/AIDS;
- integration of oral health into national health surveillance systems, which record HIV/AIDS-related health conditions;
- dissemination of information on HIV/AIDS-related oral disease, care and prevention through every possible means of communication;
- training of primary health workers in screening and provision of first-level care in HIV/AIDS-related oral disease;
- access to health facilities and provision of oral health care and health promotion for the improvement of quality of life of people infected by HIV, emphasizing the inter-relationship between oral health and general health; and
- development of positive attitudes towards oral care of HIV/AIDS patients by health workers.

"The WHO Oral Health Programme is committed to working for inter-country exchange of information and experiences in prevention of oral lesions related to HIV infection and health promotion," said Dr Poul Erik Petersen, Chief of the Oral Health Programme at WHO.

"Importantly, the Phuket declaration underlines that participants fully support WHO in all our efforts in this area."

Read more about the Oral health Programme at: [www.who.int/oral\\_health](http://www.who.int/oral_health)

Read the Phuket declaration in full at: [www.who.int/oral\\_health/media/en/orh\\_puket\\_declaration\\_en.pdf](http://www.who.int/oral_health/media/en/orh_puket_declaration_en.pdf)

[www.who.int/oral\\_health/media/en/orh\\_puket\\_declaration\\_fr.pdf](http://www.who.int/oral_health/media/en/orh_puket_declaration_fr.pdf)

## NEWS IN BRIEF

### Two WHO Departments - One patient

To ensure even greater collaboration of skills, a new WHO TB/HIV joint task force is to be established with WHO staff from both the Stop TB and HIV/AIDS departments.

The unit will address fully the impact of the TB/HIV co-infection. The cross-cutting arrangements will also increase efforts to include TB/HIV interventions within both tuberculosis and AIDS control programme plans.

"It's clear there are challenges ahead, but by strengthening cooperation and collaboration, we will be able to respond effectively," said Dr Mario Raviglione, Director of Stop TB.

"Our response has to be intense and requires co-ownership by both TB and AIDS communities, or else we will simply risk repeating the mistakes of the past."

The joint task force will also be a model for similar collaboration at regional and country office level as well as national programme level.

"We must, after all, never forget that though we are dealing with two diseases, we are very often treating one individual person," said Dr Teguest Guerma, Associate Director of HIV/AIDS Department.

### Recent publications

*Consultation on ethics and equitable access to treatment and care for HIV/AIDS* (English)

*Nutrition Counselling, Care and Support for HIV-infected women: Guidelines on HIV-related care, treatment and support for HIV-infected women and their children in resource-constrained settings* (English)

*Le module soins aigus, Soins chroniques du VIH par traitement antiretroviral, Principes généraux bonnes pratiques pour les soins chroniques, Soins palliatifs: gestion des symptômes et soins de fin de vie* - IMAI (French).

All publications can be ordered electronically at <http://www.who.int/hiv/pub/en/>.

## FEATURE

### HIV/AIDS / TB - Two diseases, one patient

*The need to address tuberculosis (TB) and HIV co-infection has never been more urgent. At an international HIV/AIDS and TB conference held in Addis Ababa in September, health experts stated that expanding access and combining TB treatment with HIV testing and antiretroviral treatment could save the lives of as many as 500 000 Africans living with HIV every year.*

*Conference participant Lucy Cheshire, a health nutritionist and TB/HIV advocate from Kenya, called for more action to address TB/HIV. Here, Lucy speaks out about the driving force behind her activism:*

"I was diagnosed with HIV in 1994. My boyfriend had suggested we have a test and I eventually bowed to his request. When we did the test he confessed he had been living with HIV for the past four years. I became suicidal. I didn't know anything about managing HIV and I was so scared about the future. However, I'm glad to say my boyfriend stood by me and continues to be a source of inspiration for me.

"Of all the years I lived with HIV, the worst time of agony, suffering, hopelessness and social ostracism was when I was diagnosed with TB. It was the year 2000 when I started experiencing persistent coughing, weight loss, night sweats and a loss of appetite. An X-ray revealed I had TB and pneumonia at the same time. Day by day things got worse. First came TB of the chest, then TB of the lymph nodes which had to be treated with surgery. A month later, while still in hospital, my knees started swelling, I had TB in my knees, which meant more operations.

"While I was still on TB treatment and undergoing repeated surgery, my CD4 count went to 50. Things got worse. I was no longer able to get out of bed, and would stay there just counting the days. I endured the pain, trauma and psychosis and now today, as a result of my diagnosis of TB and the conduct of my CD4 count, I am on ART. Although TB has resulted in insurmountable suffering, it is ironic that it created the gateway for ART.

"Now I'm healthy and alive but I still have anger within me. Last July, 18 PLWHAs gathered in Nairobi and we were told that there were still not enough resources for people who found themselves in similar life-threatening situations. Many more people would have to go through the same harrowing ordeal that I'd gone through. I just couldn't allow this to happen. It was the time to act, to fight for the TB/HIV cause. My voice had to be heard in the hope that perhaps more would be done so others would not have to suffer the same agonies I went through with TB.

"My message is simple and clear and goes out to everyone, to programme managers, to policy-makers, nongovernmental organizations (NGOs) and to people from HIV and TB communities: Do not forget people living with HIV/AIDS. TB is our killer, TB agonizes us, too many of us are dying from TB. I could have been one of those statistics in 2000 but I survived. I will continue fighting ignorance surrounding TB/HIV for as long as it takes."



Two diseases - one patient: Lucie Cheshire is fighting HIV and TB



## FROM THE FIELD

### New hope for Khayelitsha: the Fikelela Children's Centre



Mrs Noboubou and Bilatazi

*In late September, WHO HIV/AIDS technical officer for prevention/treatment linkages, Lori Hieber-Girardet travelled to the Khayelitsha settlement in South Africa to examine efforts to expand prevention to the most vulnerable in areas that treatment is also offered. Her visit took her to the Fikelela Children's Centre which, as she explains here, provides an excellent example of progress in motion.*

Driving into the dusty settlement of Khayelitsha, it might seem as if a cruel joke has been played on the people who chose the name of this shanty town outside of Cape Town in South Africa's Western Cape. Khayelitsha means "New Hope" in the local language, but with 50% unemployment, South Africa's highest murder rate and half a dozen rapes every weekend, the future of this 47-square-kilometre patch that just under a million people call home appears anything but hopeful.

But projects such as the Fikelela Children's Centre are offering promise and a solid sense of future to Khayelitsha. The Centre is more than just an orphanage for abandoned and abused children and AIDS orphans under the age of five. It is a unique example of how stigma and fear can be overcome to ensure that AIDS babies and toddlers on antiretroviral (ARV) drugs can be re-integrated into family and community life through foster families.

Mrs Noboubou is the Fikelela Centre's first foster mother and she is impatient to take two-year-old Bilatazi home with her. She has successfully completed the two-month training and bonding process, which included her visiting the Centre on a regular basis during the first month to get to know Bilatazi and, during the second, taking the little girl to spend weekends with her at the Noboubou family home. Once it was clear that Bilatazi had bonded with family, the foster mother had to convince Fikelela authorities that she would be able to provide the support necessary to ensure adherence for a twice-daily paediatric ARV drug regimen.

"My youngest daughter is HIV-positive so I am not afraid of Bilatazi's health needs," said Mrs Noboubou. "I follow a chart that I put on my wall, and tick off a box each time I give Bilatazi her medicine."

Like other future foster mothers, Mrs Noboubou has taken an adherence training course offered at Fikelela. She was taught about HIV/AIDS, its means of transmission and why it is necessary that her little foster child take the right medicines, at the right time, every day.

As nurses working in the Centre emphasize, the greatest challenge is ensuring adherence. Within the confines of the Centre, drug distribution is stringently controlled. Charts detailing the child's progress are pinned on a corkboard and carefully monitored. Once children are living with foster families, Fikelela counsellors will visit them on a weekly basis to follow their progress on ART, and to ensure adherence is strictly controlled.

Founded in 2000, by an Anglican minister Reverend Rachel Mach, the Centre is supported by donations, primarily from overseas sponsors. The British NGO One-to-One provides financial support to procure the necessary paediatric ARV drugs, which are prescribed by local doctors in the community hospital.

Two thirds of the Centre's 24 children are HIV-positive and half of those are already on ART. A team of 20 staff works in three shifts to provide 24-hour-a-day support. The Centre is housed in a simple brick building off a side street in Khayelitsha. Rows of bunk beds and a few mismatched cribs line one wall. A well-worn couch and arm chairs complete the furnishings. In a corner of the room is a white refrigerator filled with carefully labelled antibiotics, vitamin supplements and flasks of liquid formula paediatric ARV drugs.

The church is playing a critical role in providing care and support to the AIDS orphans and infected children. Recruitment of foster mothers is channelled through the local Anglican church and a foster-parent support group is currently being set up. Fikelela organizers are especially concerned that foster parents might suffer adverse reactions in their community by taking in children on ARV treatment. At the same time, they hope that by showing that children with HIV can lead productive lives on ARV, and live successfully in loving families, stigma may be overcome.

It is still too early to see the results of the fostering process. Little Bilatazi is the community's first fostered AIDS paediatric patient. However, it is clear that the Fikelela Children's Centre represents an innovative approach to supporting young children in need—not just of AIDS drugs for survival—but also of a loving family environment in which to flourish.

## VOICES

*Views on HIV/AIDS, ART and "3 by 5" from people around the world*



**Noerine Kaleeba**  
Founder, TASO  
Uganda, Community  
mobilization Adviser, UNAIDS.

As family members (spouses, lovers, parents, siblings) we have a critical role to play in making "3 by 5" a reality where it matters most, i.e. within our households, and within our communities. Our love, care and encouragement to our HIV positive family members will ensure that they not only begin treatment but that they adhere and continue with treatment. We must continue to challenge family-level stigma, and remain united as families on the long road to "living positively on treatment".



**Sunil B Pant**  
Director, Blue Diamond Society,  
an organization working on  
HIV/AIDS and Human Rights  
for sexual minorities in Nepal.

"3 by 5" is not the ultimate solution: it's only the start of addressing HIV/AIDS treatment in our part of the world. ART is the right of every PLWHA – but this hasn't been practised in many parts of the world yet. I am very optimistic about "3 by 5" – BUT, we all need to work together to make it happen. The involvement of PLWHA and vulnerable communities can make "3 by 5" a success.



**Felicita Hikuam**  
HIV/AIDS Anti-Stigma  
Campaign, International  
Federation of Red Cross and  
Red Crescent Societies

The vast majority of those living with HIV/AIDS don't actually know their status—often due to limited access to prevention information and voluntary testing and counselling services as well as the stigma attached to HIV/AIDS. Without the reduction of stigma and discrimination no treatment programme will be effective. And without prevention efforts, we cannot curb the expansion of the pandemic.

**Contributors:** Lori Hieber-Girardet, Paulo Lyra, Beth Magne-Watts, Tunga Namjilsuren, Dr Poul Peterson, Dr Randall Hyer, Glenn Thomas.