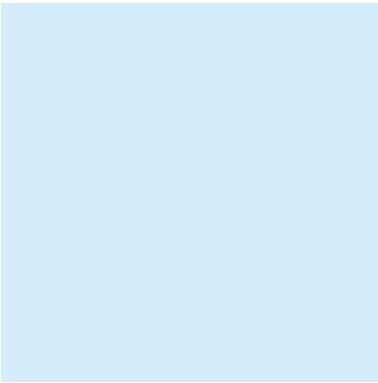
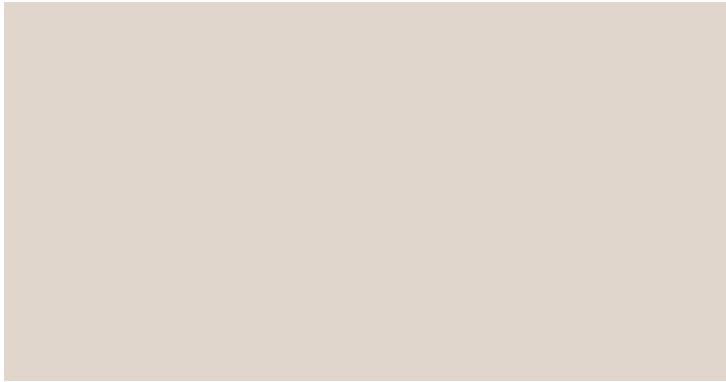


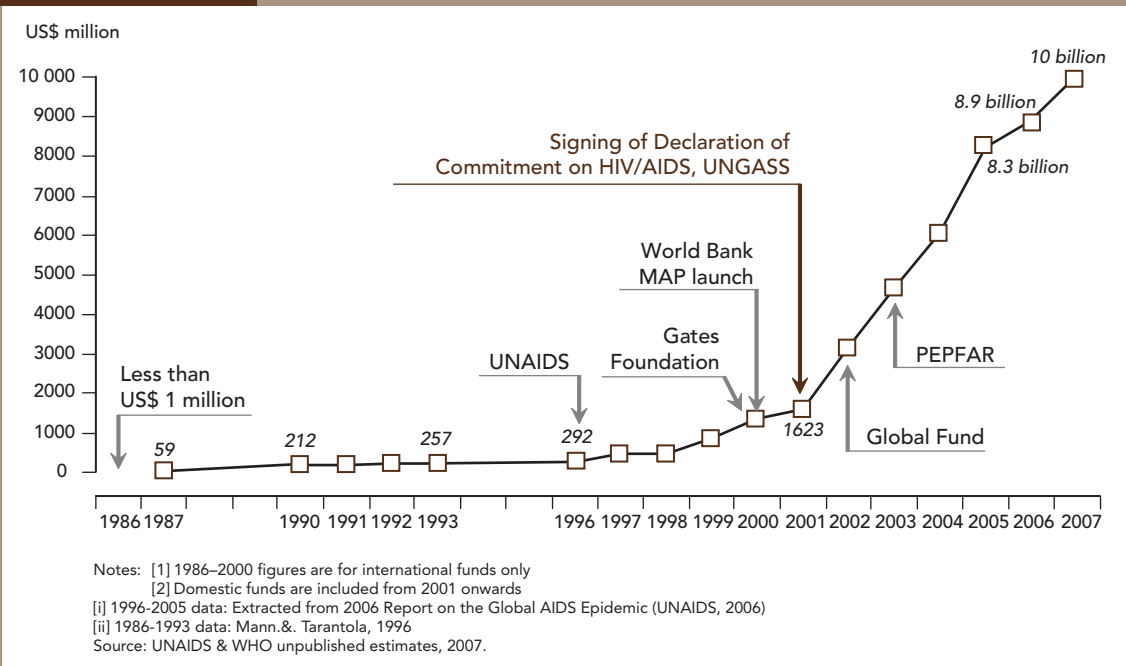
Where do we go from here? Sustaining an effective, robust HIV response for the long-term



Chapter 7



FIGURE 7.1 Total annual resources available for AIDS, 1986–2007



As discussed in previous chapters, the world currently possesses the means to prevent new HIV infections, reduce HIV-related illness and death, and mitigate the epidemic’s harmful effects on households, communities, and societies.

Moving towards universal access to HIV prevention, treatment, care, and support is an important step toward an effective, sustainable HIV response. Substantial, although variable, progress has been made in scaling up towards universal access. As Tables 7.1 and 7.2 show, several countries have already achieved their national universal access targets for prevention of mother-to-child transmission and antiretroviral treatment.

The countries that have significantly expanded the scale of these services have demonstrated strong national and decentralised leadership and

coordination of the HIV response, including alignment of funding and partners with national AIDS strategies. In countries where services have rapidly expanded, it is evident that there is clear political will from the very highest levels of government for undertaking inclusive processes that emphasize all aspects of the response and involve all relevant stakeholders. The enthusiasm and transparency with which some governments are responding to the epidemic are encouraging more development partners to support nationally owned and determined HIV strategies.

However, movement towards universal access to HIV prevention, treatment, care, and support has not occurred equally throughout the world. As Figure 7.2 indicates, certain regions lag behind in bringing critical prevention and treatment

services to scale. Progress between 2005 and 2007 in expanding access to antiretroviral treatments and preventing mother-to-child transmission was most apparent in sub-Saharan Africa. However, continued success in the region will be essential if universal access is to be achieved, as coverage levels before 2005 in Africa were extremely low.

Countries that have made notable progress towards universal access have worked to increase human-resource capacity for service delivery, improve access to commodities and equipment, and strengthen health systems more generally. Significant civil society engagement has also been essential to successful scaling up of services. An active, vocal, and engaged civil society promotes realization of human rights, expands implementation capacity in countries, and improves service access for marginalised groups and those most in need.

This chapter focuses on the steps that must now be taken, to extend the recent successes outlined in this report to all countries and regions and

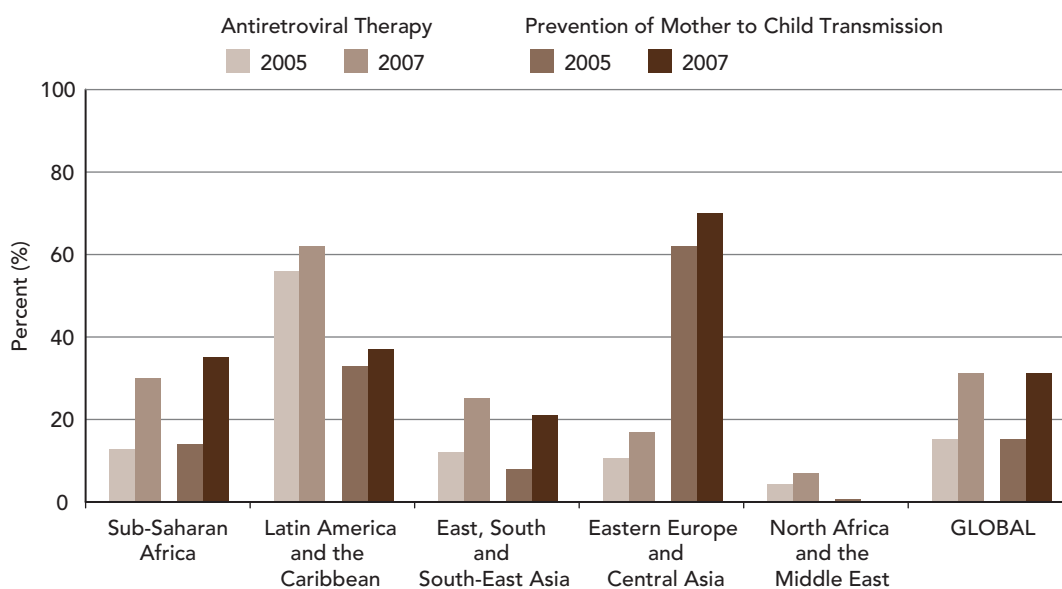
across the full breadth of the HIV response. This chapter looks beyond the 2015 deadline for the Millennium Development Goals, examining the actions and architecture that will be needed at national and global levels to sustain a robust response to HIV over the long-term.

In particular, this chapter explores the pressing challenges that individual countries, and the global community as a whole, will face in the coming years, in the quest to mount an effective, sustainable response. These challenges can be summarized as follows:

- ensuring strong and multisectoral leadership in the coming years and decades, even when other priorities emerge and improved access to antiretroviral drugs makes the epidemic seem less severe;
- implementing innovative, durable mechanisms to adequately fund the HIV response over time;
- avoiding the temptation to de-prioritize HIV prevention as the epidemic evolves,

FIGURE 7.2

Comparison of 2005 and 2007 percentage coverage of antiretroviral therapy for people with advanced HIV and percentage coverage of antiretroviral drugs for HIV positive pregnant women by region



Source: UNAIDS/UNICEF/WHO.

TABLE 7.1 Percent Coverage of Antiretrovirals for Prevention of Mother-to-Child Transmission Breakdown by Quartiles (N=63)

Less than 25% Coverage (36 Countries)	25% to 49% Coverage (16 Countries)	50% to 75% Coverage (7 Countries)	Greater than 75% Coverage (4 Countries)
Angola	Benin	Brazil	Argentina
Burkina Faso	Cambodia	Kenya	Botswana
Burundi	Central African Republic	Namibia	Russian Federation
Cameroon	Dominican Republic	Rwanda	Thailand
Chad	Gambia	South Africa	
China	Honduras	Swaziland	
Colombia	Lesotho	Ukraine	
Congo, Republic of the	Malawi		
Côte d'Ivoire	Mozambique		
Democratic Republic of the Congo	Myanmar		
El Salvador	Niger		
Eritrea	Peru		
Ethiopia	Uganda		
Gabon	United Republic of Tanzania		
Ghana	Zambia		
Guatemala	Zimbabwe		
Guinea			
Guinea-Bissau			
Haiti			
India			
Indonesia			
Iran, Islamic Republic of			
Liberia			
Madagascar			
Malaysia			
Mali			
Nepal			
Nigeria			
Pakistan			
Papua New Guinea			
Senegal			
Sierra Leone			
Somalia			
Togo			
Venezuela			
Viet Nam			

All values are based on need estimates using UNAIDS/WHO methodology. Includes all countries for which number of pregnant women receiving antiretroviral therapy was reported for 2007, except countries for which UNAIDS/WHO need estimates are not available, or with need estimates less than 500.

TABLE 7.2 Percent Coverage of Antiretroviral Therapy for Adults and Children with Advanced HIV Breakdown by Quartiles (N=106)

Less than 25% Coverage (45 Countries)	25% to 49% Coverage (40 Countries)	50% to 75% Coverage (14 Countries)	Greater than 75% Coverage (7 Countries)
Algeria	Angola	Argentina	Botswana
Armenia	Bahamas	Barbados	Brazil
Azerbaijan	Belize	Cambodia	Chile
Bangladesh	Benin	Czech Republic	Costa Rica
Belarus	Burkina Faso	El Salvador	Cuba
Bolivia	Cameroon	Moldova	Lao People's Democratic Republic
Burundi	Cote d'Ivoire	Netherlands	Namibia
Central African Republic	Dominican Republic	Panama	
Chad	Ecuador	Romania	
China	Equatorial Guinea	Rwanda	
Congo, Republic of the	Estonia	Senegal	
Democratic Republic of the Congo	Ethiopia	Thailand	
Djibouti	Gabon	Trinidad and Tobago	
Egypt	Guatemala	Uruguay	
Eritrea	Guinea		
Gambia	Guyana		
Ghana	Haiti		
Guinea-Bissau	Honduras		
Hungary	Jamaica		
Indonesia	Kenya		
Iran, Islamic Republic of	Lebanon		
Kazakhstan	Lesotho		
Kyrgyzstan	Malawi		
Liberia	Malaysia		
Lithuania	Mali		
Madagascar	Morocco		
Mauritania	Nicaragua		
Mauritius	Nigeria		
Mozambique	Papua New Guinea		
Myanmar	Peru		
Nepal	Philippines		
Niger	Poland		
Pakistan	South Africa		
Paraguay	Suriname		
Russian Federation	Swaziland		
Serbia	Uganda		
Sierra Leone	United Republic of Tanzania		
Somalia	Venezuela		
Sri Lanka	Viet Nam		
Sudan	Zambia		
Tajikistan			
Togo			
Ukraine			
Uzbekistan			
Zimbabwe			

All values are based on need estimates using UNAIDS/WHO methodology. Includes all countries for which number of adults and children on antiretroviral therapy was reported for 2007, except countries for which UNAIDS/WHO need estimates are not available, or with need estimates less than 500.

and ensuring that effective prevention interventions focus on populations and risk behaviours that are truly driving the local epidemics;

- putting in place the architecture needed to support robust, adaptable treatment and care programmes;
- mitigating the epidemic’s short- and long-term impact on households, communities, and societies;
- implementing national responses with governance characteristics that increase effectiveness and sustainability; and
- recognizing that technocratic solutions alone will not effectively manage the epidemic, but that an effective long-term response must be grounded in human rights.

The need for a stronger, more comprehensive response is clear. Continuing at the current pace of scale-up—rather than accelerating service expansion to achieve universal access to prevention, treatment, care, and support—would result in more than one million additional AIDS deaths each year by 2015 (Figure 7.3). If HIV prevention

is not brought to scale, more than twice as many new HIV infections will occur in the coming years than if a comprehensive response was implemented (Stover et al., 2006).

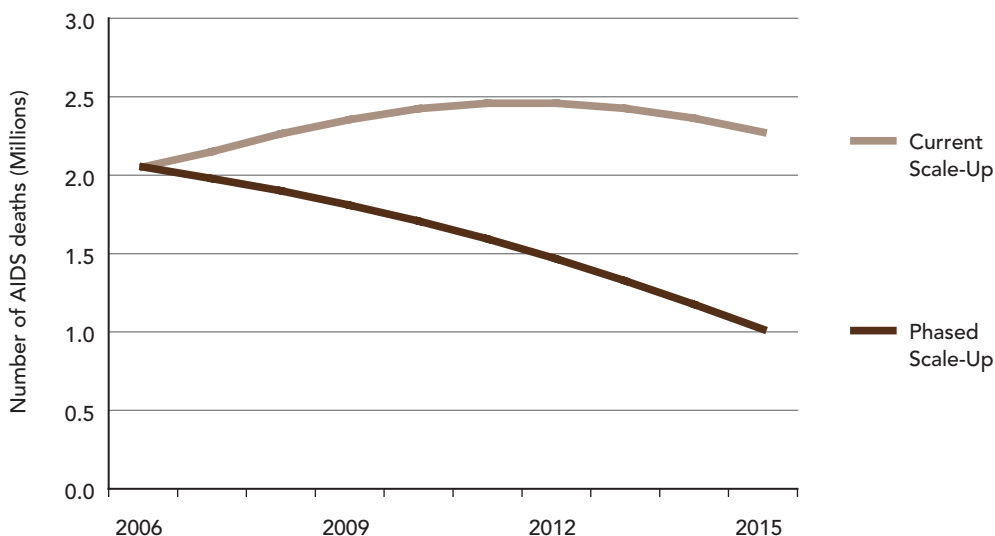
Leadership in the response

HIV presents special challenges for leadership. As Nobel laureate Amartya Sen has observed, collective action is typically easier to mobilize for visible crises such as famines, natural disasters, or the outbreak of highly infectious diseases. Yet even a “hidden” problem will eventually become apparent when its breadth and ramifications are as profound as HIV. However, almost without exception, action to address HIV has occurred too late. The epidemic’s history underscores that delaying effective action will not make HIV disappear, but will instead ensure that the problems posed by the epidemic become even more acute in the future.

The “hidden” challenge posed by HIV could further intensify in the coming years, as antiretroviral therapy is brought to scale in resource-limited

FIGURE 7.3

Annual AIDS deaths comparing projected current rate of scale up and the phased scale-up strategy to reach universal access between 2010 and 2015



Source: UNAIDS, 2008.

settings. As high-income countries have learnt over the last decade, reductions in illness and death due to treatment advances can mask continuing high HIV prevalence and incidence, potentially encouraging policy-makers and affected communities to

become complacent about the epidemic's enduring threat. True leaders will avoid being lulled into complacency and instead will pursue evidence-informed policies and programmes to reduce the epidemic's long-term toll.

National leadership in the HIV response

Recent years have provided examples of admirable leadership on HIV in a growing number of countries.

- Nine different ministries in the Government of Barbados have core HIV working groups with budgetary allocations for HIV-related activities.
- Botswana has achieved among the world's highest coverage for HIV treatment, delivering antiretroviral drugs in 2007 to more than 90% of those who need the medications.
- In 2008, concerned about the continuing high rate of new HIV infections among men who have sex with men, Brazil embarked on a major intensification of national prevention efforts focused on this population.
- In China, after years of inadequate attention to the country's growing HIV epidemic, the national government has taken important steps to respond, including establishment of almost 400 methadone maintenance clinics that were providing drug treatment services to nearly 90 000 drug users by October 2007.
- In Europe, several countries (including Ireland, the Netherlands, Sweden, and the United Kingdom) contribute a share of international HIV financing that exceeds their respective proportions of the global economy (see section on "Mobilizing sufficient financial resources for the HIV response").
- With the aim of building sufficient capacity for an effective, sustainable response, India had, by March 2007, trained more than 794 000 individuals in the delivery of essential HIV services.
- In Papua New Guinea, implementation of provider-initiated HIV testing and counselling in health-care settings resulted in a nine-fold increase in the use of testing in health-sector sites between 2006 and 2007.
- Ranking 161st out of 177 countries in the Human Development Index (UNDP, 2007), and challenged by recovering from the 1994 genocide, Rwanda achieved the highest coverage of any low-income country in 2007 for both antiretroviral therapy (71%) and prevention of mother-to-child transmission (55%).
- Beginning in 2003, the United States Government greatly increased its financial and technical assistance to low- and middle-income countries, providing an unprecedented US\$ 18.8 billion in funding for HIV prevention, treatment, care, and support initiatives (Office of US Global AIDS Coordinator et al., 2008).

Strong leadership on HIV requires a focus on long-term objectives, refusing to permit intervening challenges to undermine the national HIV response. After Brazil committed in 1996 to make antiretroviral drugs available through its public sector, the country experienced serious financial difficulties, including the collapse of the real, the national currency. Notwithstanding considerable pressure from the International Monetary Fund to sharply lower public spending, Brazilian President Fernando Henrique Cardoso remained firm on the country's commitment to providing HIV treatments. The result is the survival today of tens of thousands of people who might otherwise have died from HIV-related illness.

Leadership means avoiding the temptation to 'wish the epidemic away' once progress in the response begins to be reported. Leaders on HIV recognize that the epidemic is a generations-long challenge that requires persistence, vision, and flexibility; in short, HIV leadership means planning for the long-term. While three- and five-year planning will continue to play a key role in national responses, these processes must increasingly be situated within longer-term planning efforts. Namibia provides an example of this approach; its current five-year plan for HIV, which runs through 2009, is specifically linked to the goals and strategies of a longer-term development planning process that extends through 2030.

Leaders look to evidence for guidance. Thus, while some may be tempted to address the epidemic by placing travel restrictions on people living with HIV or by limiting prevention for young people to lessons on remaining sexually abstinent, leaders on HIV will be persuaded by public health evidence that such strategies are ineffective and counterproductive.

Leadership from heads of government and national ministries is critical, but effective national responses depend on commitment and action from different groups. Leadership on

HIV is needed from all walks of life (especially in countries where HIV is hyperendemic) including community groups, faith-based organizations, private businesses, and young and old. Above all, people living with HIV must be empowered to help lead national responses.

By providing essential services, promoting tolerance and compassion, and advocating for stronger action, faith-based groups in all regions are essential partners in the response. Faith-based groups that are helping lead the HIV response include Caritas Internationalis, Ecumenical Advocacy Alliance, Tear Fund, Islamic Relief, the Sangha Metta Project, and the Art of Living foundation. Likewise, parliamentarians have a vital role to play in leading and strengthening national responses. This was reflected in the First Global Parliamentary Meeting on HIV/AIDS in November 2007, hosted by the Philippines Senate, where nearly 200 parliamentarians from countries in all regions agreed to take bold steps to increase treatment access, reduce stigma and discrimination, strengthen evidence-informed HIV prevention, and improve the effectiveness of national responses.

Engaging nongovernmental actors in the HIV response may sometimes require innovative approaches. For example, to encourage greater business involvement in the national response, the Chinese Government launched a new policy in 2007 that permits tax deductions for business donations to HIV prevention and care activities. At the global level, the Global Business Coalition on HIV/AIDS and the World Economic Forum continue to generate greater action and commitment on HIV from private industry.

Discover and recover

Reverend Patricia Sawo is Regional Coordinator for ANERELA+, Eastern Africa



One morning in September 1999, Patricia Sawo awoke in terrible pain and discovered that her body was covered in shingles, a common opportunistic disease in people living with HIV. At the time, she was a church leader in Kenya and was training as a Christian counsellor. Her fear that this indicated HIV infection threw her into turmoil.

“I had been one of those preachers who believed that HIV was a curse and a punishment from God”, she says. Later, she confided in two colleagues, who advised her that seven days of fasting and prayer would bring healing from God. But she continued to test HIV-positive.

When church leaders began discussing strategies to identify and isolate all HIV-positive people, Sawo decided to go public about her status. But her courage had disastrous repercussions: in two weeks Sawo lost her position of leadership in the church, and was forced to end her studies. Her husband lost his job, and the family lost their home, because of HIV-related stigma. All but two of Sawo’s friends deserted her. Without any form of support, the children were forced to leave their schools.

“For two years I lived in loneliness and isolation”, says Sawo. “But I could see that I was not going to die. I walked into an NGO and asked them if they could train me as a church leader.” Through them, she made contact with other HIV-positive clergy, and in 2002 she attended a meeting of HIV-positive church leaders in Uganda. There she met Canon Gideon Byagumisaha who had been living with HIV for 10 years. “I heard three very powerful words and my life changed. He said HIV is preventable and manageable, and death is avoidable.”

At this meeting, ANERELA+, the African network of religious leaders, was established. The network has three main objectives:

- to establish a network of religious leaders living with or affected by HIV;
- to empower church leaders to become agents of change; and
- to empower church leaders to stimulate discussion and action on HIV and AIDS in their home congregations.

“ANERELA+ gave me a family”, Sawo says. She began working on ANERELA+’s behalf to establish a religious network in Kenya. Her job with ANERELA+ helped the family financially, enabling her children to return to school. Her daughter, who would have become a maid, is now at university.

When Sawo first began speaking about HIV, people started coming for help in such numbers that her house became like a clinic. This led her and other church members to establish a centre where people could get care and support. Their first visitor was a man suffering from acute meningitis who had been dumped in the road outside the hospital. After treatment, he was brought to the centre where his care continued. This man has now fully recovered and is back at work after two years of incapacitating illness. Called “Discover and Recover”, the centre helps prevent many unnecessary deaths from AIDS. Initially it was a day-care centre, but has grown to include a nursery school for 28 children affected by HIV.

Engaging people living with HIV as essential partners in the national response

At the 1994 Paris AIDS Summit, 42 countries declared the greater involvement of people living with HIV (GIPA) to be critical to national HIV responses. Engagement of people living with HIV in the development, implementation, and monitoring of national efforts is not solely a question of fairness. The effectiveness of national HIV initiatives depends on their resonance with those most affected by the epidemic. Therefore, the perspectives and insights of people living with HIV are invaluable assets, which can help ensure that national efforts achieve maximum impact.

To date, there have been few tools to measure the engagement of people living with HIV in national responses. In 2005, a global “think tank” meeting of people living with HIV resulted in agreement to develop a “GIPA report card”, to permit country-level assessments of GIPA engagement. This effort was subsequently spearheaded by the Global Network of People living with HIV/AIDS (GNP+). In early 2008, the report card was being piloted in India, Kenya, Lesotho, and Trinidad and Tobago, with expectations for wider implementation in coming years.

Sustaining long-term financing for HIV

While money alone will not ensure long-term success, a robust HIV response cannot be sustained without adequate funding. Even in low-income countries, domestic public sector budgets have a critical role to play in financing the long-term response. Nevertheless, the global community, having committed to reversing the epidemic, must recognize the limited ability of low-income countries to fund essential HIV services. In low- and middle-income countries, international donors will need to provide most of the financing for HIV in the coming years.

It is unrealistic to expect HIV-dedicated funding to fully support the broad array of economic and social actions that will strengthen the HIV response. These actions include universal primary and secondary education, meaningful economic opportunities for women, comprehensive and well-functioning social protection systems, and support for agricultural sectors and rural communities. International donors should generate the financing needed to achieve universal access to HIV prevention, treatment, care, and support, but they should

also substantially increase funding for official development assistance of all kinds. Broad-based progress on non-HIV-specific indicators in health, economic, and social aspects are urgently needed to maximize the impact of national HIV responses. It is disheartening to note that most high-income countries have failed to honour promises to devote at least 0.7% of their gross national product to official development assistance. As of 2005, only five country members of the Organization for Economic Cooperation and Development (Denmark, Luxembourg, Sweden, the Netherlands, and Norway) were investing at least 0.7% of gross national income towards development assistance (UNDP, 2007a).

The quest for sustainable financing for HIV response has led to a number of imaginative initiatives. For example, Product RED, the brainchild of Bono and Bobby Shriver, chair of DATA (Debt AIDS Trade Africa), devotes a percentage of each product sold towards the Global Fund. Participating companies include clothing retailers (such as Gap, and Emporio Armani), American Express, leading computer makers (such as Apple, Dell, and Microsoft),

It concerns everyone

Gary M. Cohen is Executive Vice President of Becton Dickinson



"My involvement in HIV/AIDS really was an outgrowth of travels in the developing world", says business leader Gary Cohen. "I became involved, not only on a professional level, but also on a very personal level, following personal exposure to the impact of HIV/AIDS in sub-Saharan Africa."

On his many journeys in the region with UNICEF, Red Cross, and other agencies, Cohen found that every family had lost loved ones and been touched by the epidemic in many ways. This led him to an understanding of HIV as the most important health threat of our time; a health threat with a direct impact on the business community. "I personally think it would be extremely short-sighted for any global organizations—even for small or middle sized companies—to regard this as an issue that does not concern them", says Cohen.

Cohen is executive vice president of Becton Dickinson (BD), a leading medical technology company with annual revenues of approximately US\$ 6.5 billion and 28 000 people worldwide. Cohen's personal commitment to the response has led him to actively pursue ways in which his company can address the HIV epidemic. In addition to strong workplace programmes, BD supports the AIDS response through careful collaborations with existing organizations and agencies. For example, BD has worked with PEPFAR to strengthen laboratory systems throughout sub-Saharan Africa. The company has committed half of the US\$ 18 million budget, as well as providing technical assistance.

BD is also collaborating with the Clinton Foundation to ensure sustainable access to CD4 testing, and with the FIND foundation to improve tuberculosis diagnosis. Other collaborations provide training and support for health workers and health systems in high-prevalence countries. For example, BD has trained more than 2500 laboratory technicians, and supported the establishment of Wellness Centres for Nurses affected by HIV.

Cohen believes that all companies have a contribution to make, according to their core competencies. "With HIV/AIDS, it is easy to get caught up in big numbers and almost become numbed to it", he says. "What I encourage people to do is reduce it to a single number ... go and meet one person who is living with this disease or who's been affected by this disease."

In 2004, Cohen met a 14-year-old Kenyan orphan who had been diagnosed as HIV-positive. He took responsibility for her and now she is in a top-quality school, performing near the top of her class, and dreams of one day becoming a lawyer.

hoteliers, newspapers, and the Hallmark greeting card company. In its first two years, Product RED raised more than US\$ 100 million to support essential health programmes in low- and middle-income countries.

Another creative financing vehicle for HIV is UNITAID, launched in 2006 with leadership from the governments of France, Brazil, Chile, Norway, and the United Kingdom. UNITAID is an international drug purchase facility funded through an international airline tax, which ensures a continuous flow of revenue. As of March 2008, more than 24 countries had either implemented the airline tax or were planning to do so. As Chapter 5 explained, UNITAID in its brief existence has already come to play an important role in the expansion of HIV treatment access for children.

In February 2008, UN Secretary-General Ban Ki-moon appointed former French Foreign Minister Philippe Douste-Blazy as a special adviser on innovative financing for the Millennium Development Goals. Douste-Blazy has argued for the development of a world-wide citizen movement to generate sustainable financing for international development aid.

Making the money work

Additional efforts are also needed to ensure that increased financing can be rapidly translated into sound, high-impact programmes in low- and middle-income countries. In addition to maximizing the coordination of different funders and providers, technical support will be needed to build national capacity to mount and sustain strong HIV responses that focus on those most at risk and vulnerable. Donor policies should also support, rather than impede, the engagement of civil society and affected communities in national HIV responses.

Harmonization and alignment

Greater progress is needed to bring the efforts of all country-level players into alignment with nationally owned and determined strategies.

Nearly half (45%) of governments report that not all external partners align their efforts with national HIV strategies (UNGASS Country Progress Reports, 2008). Where national stakeholders pursue their own individual agendas, the strategic impact of HIV efforts is often muted.

Reducing uncertainty of financing.

The uncertainty of external financing inhibits the ability of countries to plan for the future, a particular impediment for national efforts to ensure the long-term sustainability of the HIV response. While the global trend of in-country disbursement from bilateral donors has steadily increased, the availability and magnitude of funding from specific donors continues to change from year to year. One possible response to this problem is “basket funding”, whereby multiple donors pool their financing in multiyear grants to support national responses.

Engaging and funding civil society.

The HIV response has placed people at the centre of development practice. For example, the World Bank’s Multi-Country HIV/AIDS Program mobilized more than 66 000 civil society organizations to participate in the HIV response in Africa (World Bank, 2007). Similarly, the Global Fund has pursued a novel approach, relying on broadly inclusive country bodies to assess needs, formulate programmes, and submit applications for multiyear funding. These and other innovations will continue to be needed in the coming years, to ensure broad participation and engagement in national HIV responses.

Overcoming implementation bottlenecks

Coordinating the efforts of funders and technical agencies is critical to early identification of implementation bottlenecks, timely delivery of technical assistance to expedite implementation and scale-up, and capacity-building to ensure the sustainability of national responses. Supporting countries to successfully implement grants from the Global Fund represents one of UNAIDS’ highest priorities.

Improving the relevance and impact of UN technical support to countries

To increase the coherence and effectiveness of UN efforts on HIV, the UNAIDS Cosponsors and Secretariat have agreed to a division of labour for the provision of technical support. This division of labour identifies lead and collaborating agencies in particular thematic areas, taking advantage of each agency's expertise and comparative advantage with respect to specific issues. The implementation of these recommendations was independently evaluated, and the evaluation found that UN agencies have adopted the division of labour, adapting it as appropriate in national settings. Several agencies have adjusted their staffing levels in direct response to their revised responsibilities (Attawell & Dickinson, 2007).

The UN has taken other steps to improve the quality, timeliness, and impact of its support to countries. Technical support facilities will have been established in seven regions by the end of 2008, and WHO has established regional "knowledge hubs" to help countries translate strategic information into programmes and policies.

Technical support facilities provide timely, high-quality technical support to country partners in priority areas (strategic and operational planning, costing and budgeting, monitoring and evaluation, programme and financial management) and in regionally defined thematic areas. The facilities have established pools of local and regional consultants, and provide professional development services to increase the capacity of locally provided technical support. They work in partnership with UNAIDS Cosponsors to ensure that policies, methodologies, and tools used by their consultants are state-of-the-art, and promote shared values and understanding of UN and global agreements. Particular attention is given to increasing access to Global Fund grants, by providing technical support to Global Fund recipients to develop proposals and implement grants.

In 2008, UNAIDS and the Global Fund entered into a comprehensive framework to improve the coordination and effectiveness of their respective efforts to aid countries in moving towards universal access to HIV prevention, treatment, care, and support. Under the agreed division of responsibilities, UNAIDS helps countries to develop evidence-informed funding proposals, supports the Global Fund's technical review process, and provides countries with focused technical assistance to accelerate implementation of programmes approved by the Global Fund.

The Global Implementation Support Team (GIST)—a novel collaboration between the

Global Fund, UNAIDS, UNFPA, UNICEF, WHO, the World Bank, UNDP, GTZ, the United States Government, the AIDS Alliance, ICASO, ICAD, and ICTC of Brazil—work together in a collaborative and coordinated way to solve major bottlenecks inhibiting the provision of universal access to HIV prevention, treatment, care, and support services. An independent evaluation found that the GIST mechanism has improved coordination among multilateral funders and technical agencies, and has helped drive reforms at the global level to increase the efficiency and impact of multilateral support to countries (Attawell & Dickinson, 2007).

Maintaining a strong focus on HIV prevention

As emphasized in Chapter 4, long-term success in the HIV response demands sharp and sustained reductions in the rate of new HIV infections. Yet HIV prevention is consistently under-prioritized in many national responses. Nearly three decades into the epidemic, most young people in heavily-affected countries lack basic knowledge about HIV; about two out of three HIV-positive pregnant women do not receive antiretroviral drugs and other services to prevent mother-to-child transmission; and in countries with concentrated epidemics, most populations at greatest risk of exposure to HIV do not receive even basic HIV prevention services.

Unfortunately, preventing new HIV infections may not become easier as the epidemic evolves. As treatment access increases, the disability and death associated with HIV could become less visible, encouraging communities to become complacent, and tempting leaders to reduce investments in prevention programmes. Success in lowering the epidemic's human toll may cause some countries to declare premature victory in the HIV response. And as difficult budget decisions inevitably arise, some decision-makers may find it simpler to reduce funding for prevention services that, by definition, lack clear, demonstrable outcomes because they are intended to prevent negative consequences from occurring.

In many respects, prioritizing HIV prevention represents the ultimate manifestation of HIV leadership. Supporting evidence-informed prevention efforts requires countries to address difficult issues, invest wisely in the future, and address the societal factors that increase HIV risk and vulnerability. Until sufficient political will exists to put in place the HIV prevention strategies demonstrated to be effective, the epidemic will continue to expand, undermining the sustainability of the HIV response.

Availability of prevention services will not automatically ensure their widespread uptake. Where

HIV prevention has succeeded, a popular movement has endeavoured to make risk reduction a societal norm, generating strong demand for prevention services. This also requires strong leadership. Much has been learnt about how to generate and support strong community mobilization, but encouraging such a popular movement requires the courage to invest in strategies that increase the HIV accountability of national governments and other stakeholders. Some may resist being held accountable, but true HIV leaders will welcome the development of a genuine social movement as a critical ingredient of success.

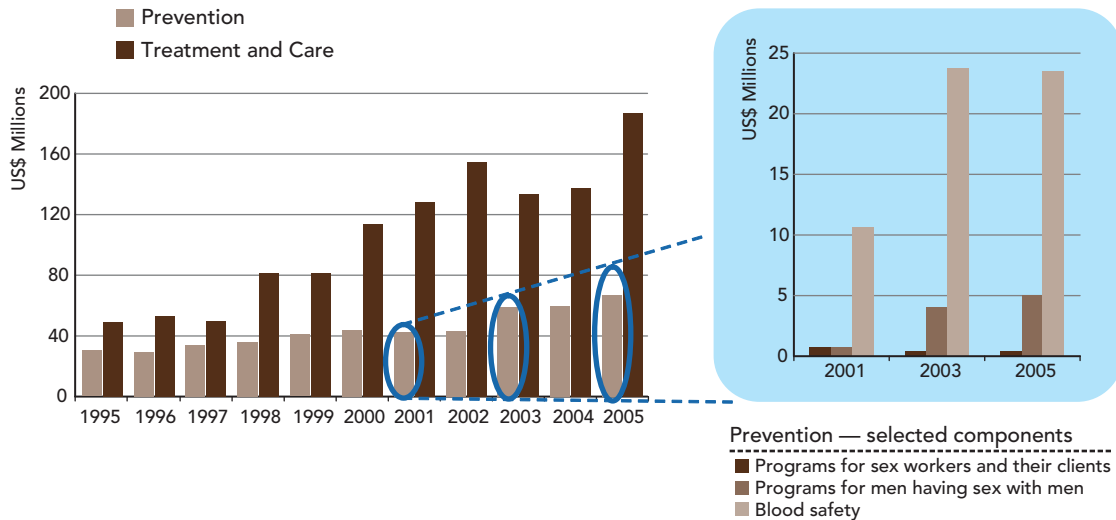
Tailoring national responses to documented needs

Countries need sound, timely information on their epidemic and on the status of the response, to permit rational selection of priority programmes, most effective allocation of limited funds, and implementation of the policies calculated to best address the underlying dynamics that increase HIV risk and vulnerability. This is true for all aspects of the epidemic, but it is particularly critical to the success of HIV prevention efforts. For example, understanding the transmission dynamics of the last 1000 new HIV infections would help countries to implement prevention measures focused on the groups at greatest risk of HIV exposure, and on the factors that appear to be driving the epidemic's spread. Epidemiological assays have emerged in recent years that improve the ability to assess the rate and characteristics of new HIV infections in selected low-level and concentrated epidemics (McDougal et al., 2006), although these have not been validated for use in generalized epidemics. However, modelling techniques are available to enable countries to make short-term estimates of new HIV infections, including identifying the modes of transmission (Gouws et al., 2006).

Information on new HIV infections should be complemented by reliable data on relevant behaviours. Both UNICEF and the United

FIGURE 7.4

HIV spending on prevention, treatment, and care, Mexico, 1995–2005 (US\$ millions)



Source: Personal communication with Centro Nacional para la Prevención y control del SIDA (CENSIDA), Ministry of Health, Mexico (2008).

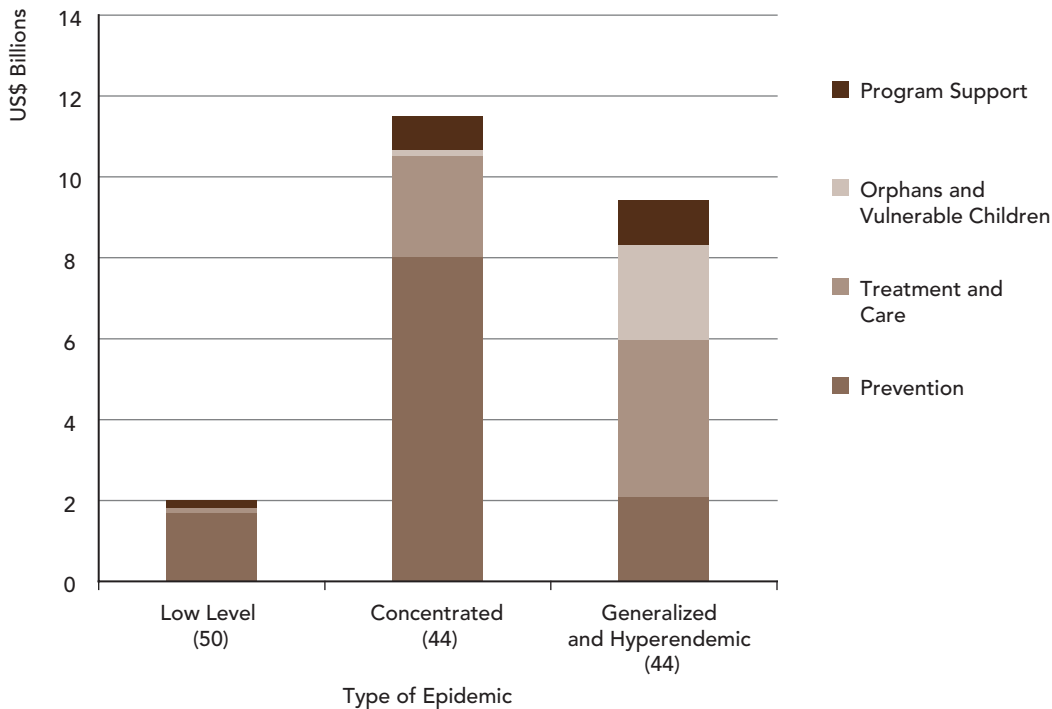
States Agency for International Development (USAID) have made critical contributions to behavioural epidemiology, by sponsoring household surveys that collect information on sexual debut, number of sex partners, HIV status, and other relevant issues. In some settings, however, such surveys may need to be tailored to elicit the range of information needed to support rational development of prevention strategies. For example, questions regarding the number of sex partners may shed little light on the frequency and duration of partnership concurrency, a potentially important factor in the rate of HIV spread. Countries should take particular efforts to ensure that national information systems generate data pertinent to the populations most at risk of infection.

Countries should use improved HIV information to increase the strategic impact of prevention efforts. In recent years, numerous countries have developed or devised national strategies on the basis of emerging information. In both Madagascar and Morocco, evidence documenting the practice of injecting drug

use persuaded national authorities to allocate resources towards initiatives aimed at reducing the risk of drug-related transmission of HIV. As Figure 7.4 shows, earlier this decade Mexico heeded evidence documenting the high rate of HIV infections among men who have sex with men and increased expenditures for HIV prevention, after years of static funding.

Too often, however, national HIV expenditures do not match national needs. This is especially the case in many countries with low-level or concentrated epidemics, where rational funding would focus primarily on HIV prevention services for populations most at risk of HIV exposure. In countries with generalized epidemics, more resources are required for treatment, care, and social mitigation (Figure 7.5). Most countries in Latin America have low-level epidemics (HIV prevalence is well below 1%) but HIV prevention accounted for just 15% of HIV spending in 2007. Countries with concentrated epidemics often opt for broad prevention programmes for the general population rather than for more cost-

FIGURE 7.5 Resources needed in 2010 using a phased scale-up strategy towards universal access*



* Estimates in 138 low- and middle-income countries for implementing the most effective programmatic services as determined by data derived from national efforts to "know and act on your epidemic"
Source: UNAIDS, 2008.

effective interventions focused on populations most at risk. Data from countries with concentrated epidemics suggest that risk-reduction programmes focused on populations most at risk represent only 10% of overall HIV prevention spending.

Recognizing the long-term nature of investing in treatment and care

Chapter 5 examined recent successes in expanding treatment access, and potential obstacles to the sustainability of treatment programmes. Antiretroviral treatment is for life, underscoring the imperative of ensuring the continuity of HIV treatment programmes.

Improved prevention of new HIV infections is critical to the continued viability of HIV treatment programmes. Future treatment

challenges are already daunting, with 30 million people living with HIV but not yet receiving treatment. Unless the epidemic's expansion is halted, future prospects for ensuring universal access to antiretroviral drugs will be uncertain, at best.

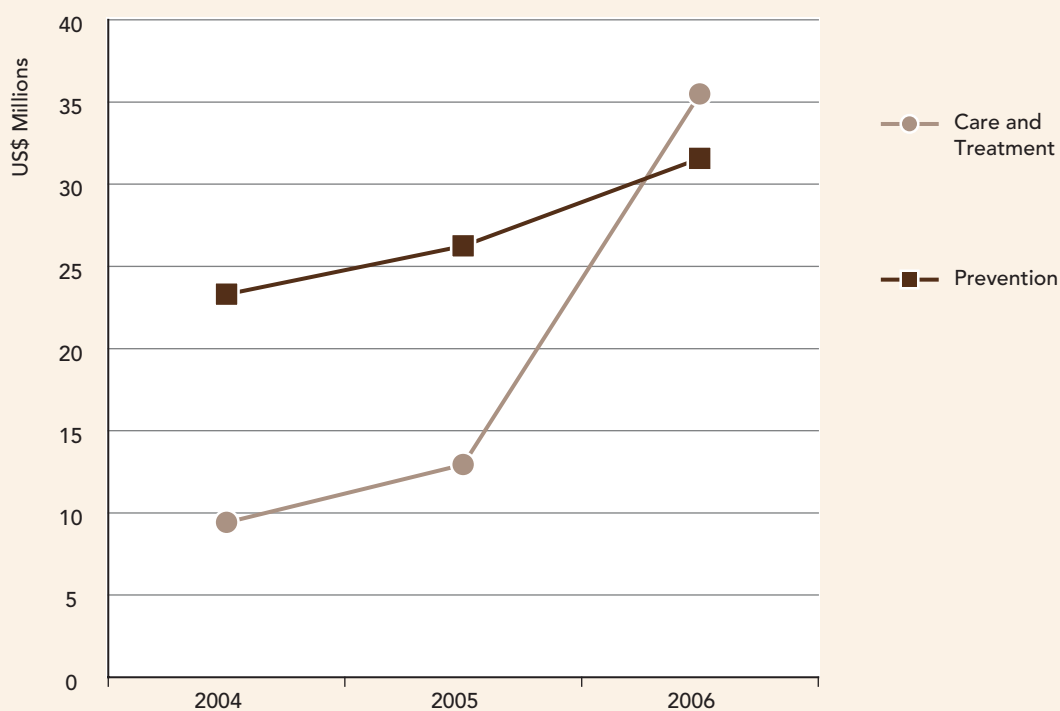
Ensuring sufficient human resources to implement and monitor HIV prevention, treatment, care, and support programmes will require both ingenuity and long-term commitment. Sustained investments in education and training initiatives, task-shifting and other innovative strategies to extend existing capacity as far as possible, and continued national commitment to antiretroviral treatment programmes, will be needed to build the long-term capacity required to maintain national responses at a high level in the future (see Samb et al., 2007).

Allowing evidence to drive the national response in Mozambique

Infection rates in Mozambique are increasing but infection rates in neighbouring countries are stabilizing. HIV prevention accounted for a decreasing share of Mozambique's HIV expenditures between 2004 and 2006 (Figure 7.6) and the main component of the increasing care and treatment expenditure is for antiretroviral drugs.

FIGURE 7.6

Prevention, care and treatment expenditures from public and international funding sources—Mozambique, 2004–2006, US\$ millions



Source: UNGASS Country Progress Reports 2008.

In light of evidence of increasing infections, Mozambique recognized the need to strengthen HIV prevention. The country established a multistakeholder Prevention Reference Group in October 2007, which aimed to build the evidence base needed to intensify HIV prevention. With participation of various national ministries, the National AIDS Council, international technical agencies, and civil society, the reference group is assembling evidence to identify and characterize the key drivers of the epidemic. Rapid behavioural and epidemiological surveys in key populations are being undertaken, and relevant HIV activities are being mapped. This collective body of data will enable Mozambique to establish evidence-informed policies, prioritize programmes, and appropriately allocate available HIV prevention resources.



Reducing the epidemic's burden is critical to achievement of the full array of Millennium Development Goals.

In the process of establishing national targets, many countries have come to recognize specific obstacles to the rapid scale-up of services. A “phased scale-up” approach to moving towards universal access, which assumes different rates of scale-up for each country, based on current service coverage and capacity, will require approximately US\$ 970 million annually in human resource initiatives by 2010 (UNAIDS, 2007c). This scenario envisages that each country will reach universal access for specific interventions at different times, with essentially all countries achieving universal access by 2015. While limited capacity sometimes impedes treatment scale-up, the global commitment to expand treatment access is also driving major improvements in health systems, and a robust HIV response has the potential to overcome barriers to service delivery.

In 2001, African leaders committed to prioritize improvements to the health sector in national budget allocations (Abuja Declaration Organization of African Unity, 2001). Government health spending in low-income countries generally has risen modestly since the late 1990s, but a number of African countries spend a substantially smaller share of national resources on health than neighbouring countries and most countries in other regions (UNDP,

2007a). India, home to an estimated 2.5 million people living with HIV, spends only 0.9% of its national GDP on health (UNDP, 2007a). Development economists suggest current spending levels on health in low-income countries are only one quarter to one third of the amount needed to ensure delivery of basic health services (Center for Global Development, 2007). To sustain the long-term HIV response, substantially greater health spending—from both domestic and external sources—will be required.

Cheaper second- and third-line drugs are urgently required for treatment programmes to be sustainable. This imperative is already attracting the efforts of stakeholders at global and national levels, and these efforts should be intensified and broadened to maximize treatment success in future years. Similar attention is needed to make the full range of HIV diagnostic technologies more accessible. Importantly, global and national flexibility will be needed to adapt to new developments in therapeutic and diagnostic tools for HIV. In particular, greater financial and technical support, and improved regional cooperation, should be focused on building the capacity of national regulatory bodies to introduce safe and effective medical products needed for the clinical management of HIV infection.

The HIV response in high income countries

Twenty-three high-income countries reported their progress towards the implementation of the *Declaration of Commitment on HIV/AIDS* in 2008, which was an increase from 15 countries in 2006. The 2008 responses comprised 49% of all high-income countries, which remains well below the 84% response rates from low- and middle-income countries. The high-income countries on average reported on 10 indicators compared with an average 16 out of 25 indicators on which the 124 low- and middle-income countries reported.

Coverage of antiretroviral combination therapy was on average greater in high-income countries compared with levels reported by low- and middle-income countries. Although most high-income countries have either concentrated or low-level HIV epidemics, only 17 of 23 high-income countries reported information on populations most at risk of HIV exposure. Response rates were higher for HIV testing indicators compared with HIV prevention and knowledge indicators. Access to HIV services for documented and undocumented migrants is not uniform among high income countries, even those within the European Union. While members of these groups have free access to HIV services at point of delivery in some European countries, in others access to HIV services for these populations are only on a fee-for-service basis.

In some high-income and low- and middle income countries, changes in young people's sexual behaviour were observed between 1995 and 2002. For example, national school-based behavioural surveillance in the United States demonstrated that the proportion of young males having sex before the age of 15 declined from 21% in 1995 to 15% in 2002. A similar decline was seen among young women from 19% to 13%¹. This compares with a reduction from 15% to 12% in young men and from 12% to 11% in young women in 23 low- and middle-income countries surveyed over the same time period².

It is unclear why reporting rates are substantially lower in high-income countries. This may be partly due to the fact that the relevant data are not held in a central location and are administered by different institutions. Although there are notable exceptions, this under-reporting raises questions about the progress of high-income countries in implementing a single, integrated HIV monitoring and evaluation framework, or "Third One".

¹ Abma JC et al., Teenagers in the United States: sexual activity, contraceptive use, and childbearing, 2002, Vital and Health Statistics, 2004, Series 23, No. 24.

² DHS www.measuredhs.com

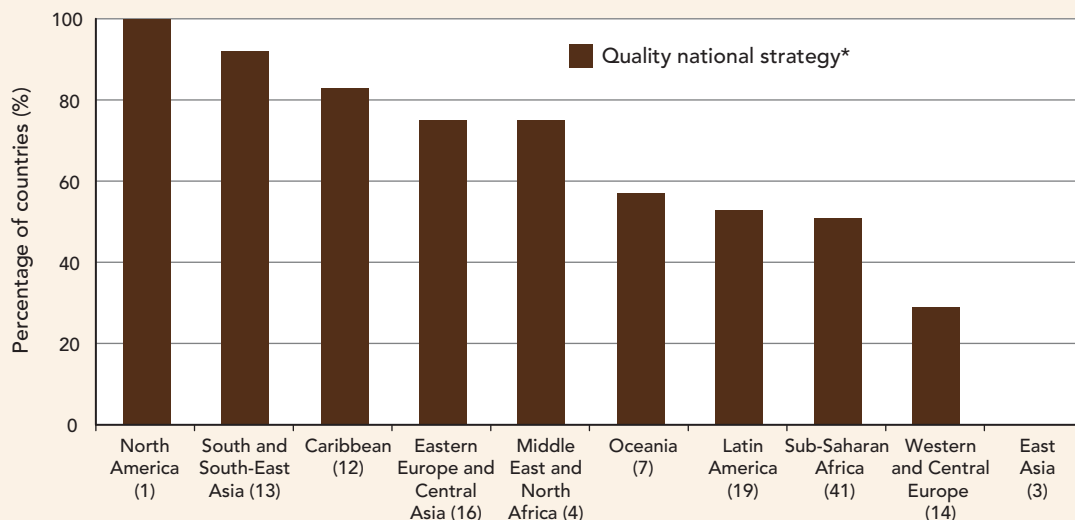
Ensuring coordination and coherence of national efforts

In line with international efforts to improve the harmonization and alignment of international development aid with country-owned strategies and plans, country-level action on HIV aims to promote the “Three Ones”—one national AIDS authority, one national strategic framework, and one national monitoring and evaluation system.

Multisectoral, costed, and prioritized strategies for national responses are in place in most countries. A total of 97% of countries have a multisectoral HIV strategy, 92% have a national HIV coordinating body, 92% have a national monitoring and evaluation plan in place or in development, and all low- and middle-income countries have integrated HIV into national development plans.

However, when country-level efforts are evaluated according to quality criteria developed by UNAIDS, the weaknesses of many national approaches become apparent. In only 69% of countries—far fewer than the 97% that report having a national strategy—have national strategies been translated into costed operational plans with programme goals, detailed programme costing, and identified funding sources. In sub-Saharan Africa, only about half of national HIV strategies meet UNAIDS quality criteria (Figure 7.7).

FIGURE 7.7 Countries reporting quality implementation of the national AIDS strategy



(Number of countries reporting) (N=130)

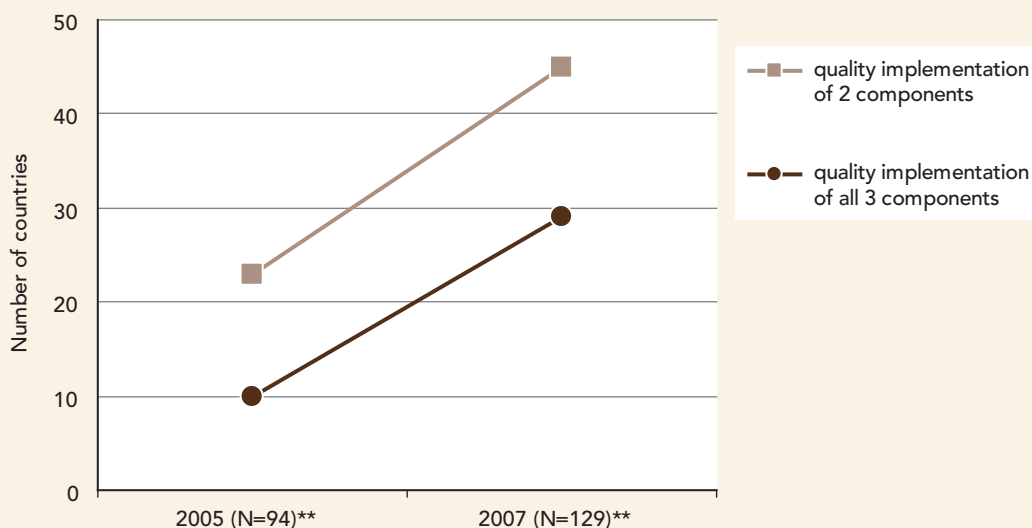
* One national multisectoral strategy and operational plan with goals, targets, costing, and identified funding per programmatic area, and a monitoring and evaluation framework.
 Source: UNGASS Country Progress Reports 2008.



Despite continuing weaknesses, country-level efforts under the “Three Ones” exhibit important improvement over time (Figure 7.8). Indeed, many countries have used the “Three Ones” principles to drive improvements in national preparedness. In 2007, for example, Tajikistan developed its first national plan for HIV monitoring and evaluation, supported by a detailed budget and focused on national indicators agreed to by all national partners. In Indonesia, a presidential decree in 2006 clearly established the National AIDS Commission as the sole body responsible for leading and coordinating the country’s HIV response.

FIGURE 7.8

Country progress in improving the implementation quality of the “Three Ones”: one national strategic framework, one national AIDS authority, and one national monitoring and evaluation system*



* Quality implementation refers to:

- 1 One national multisectoral strategy and operational plan with goals, targets, costing, and identified funding per programmatic area, and a monitoring and evaluation framework;
- 2 One national coordinating body with terms of reference, a defined membership, an action plan, a functional secretariat, and regular meetings;
- 3 One national M&E plan which is costed and for which funding is secured, a functional national monitoring and evaluation unit or technical working group, and central national database with AIDS data.

** Only countries that have all three or two of the three components in place are displayed; other countries have only one or none of the components in place, or did not report.

Source: UNGASS Country Progress Reports 2008.

National governments are increasingly partnering with civil society in the development, implementation, and monitoring of national HIV strategies. According to government reports, 83% of national HIV coordinating bodies include civil society representatives (UNGASS Country Progress Reports, 2008). In most cases, governments report that the national strategy or framework was developed with active participation from civil society (ranging from 62% in South and South-East Asia to 100% in North America). Civil society members have been involved in the review of national HIV strategies in 78% of countries, and rated their contribution as good or very good with respect to national planning and budgeting in 58% of countries.



Achieving universal access to HIV prevention, treatment, care and support is as critical step towards a sustainable, long-term response to HIV.

Mitigating the epidemic's long-term impact

Treatment scale-up will help to contain and minimize some of the epidemic's most severe ramifications, but will not make either HIV or its harmful consequences disappear. Substantially less attention has been directed towards intervention research and scale-up of programmes relating to impact mitigation than for other aspects of the HIV response. For example, access to HIV treatment, prevention of mother-to-child transmission, and other essential HIV services has significantly expanded in recent years, but little progress has been made in delivering essential care and support to children orphaned or made vulnerable by the epidemic.

Working to minimize the epidemic's impact is not only a humanitarian imperative, it is also

part of the long-term response to the epidemic. The millions of children affected by HIV represent the future; providing proper care and support to such children and the households in which they live is critical to the long-term health and well-being of entire societies and communities. Likewise, households that slip deeper into poverty as a result of HIV illness will find it even more difficult in future years to prosper and contribute to society.

As Chapter 6 emphasized, a "silo" approach to impact mitigation will not be optimally effective. Instead, countries need cross-cutting planning and oversight mechanisms to address the multiple, complex ways in which HIV affects societies, communities, and households. It is therefore essential to mainstream HIV impact mitigation efforts into broader development strategies.

Governance of the response

Countries confront a host of governance challenges in their efforts to respond effectively to HIV. Throughout the epidemic, countries have struggled to achieve a response that is genuinely multisectoral and actively owned and led by national stakeholders. Coordination of diverse actors at country-level also remains an ongoing challenge.

Significant progress has been achieved on each of the “Three Ones” principles—a single multisectoral action framework, a single national HIV coordinating authority, and a unified monitoring and evaluation system (see box “Ensuring coordination and coherence of national efforts”). In too many countries, however, these achievements are more evident on paper than in practice.

Although national HIV strategic frameworks almost uniformly articulate an approach to HIV that is multisectoral, the response in many countries remains heavily concentrated in health ministries. While non-health ministries often participate in national coordinating bodies, which is an important achievement, many lack budgetary support to undertake HIV-related activities. For example, although 98% of countries have a national HIV strategy that includes the education sector, only 65% provide budgetary support for HIV programming in educational settings (UNGASS Country Progress Reports, 2008). Malawi’s mandate to diverse ministries to earmark budgetary support for HIV activities (see section on “Mobilizing sufficient financial resources for the HIV response”) offers an example of how countries can facilitate the active engagement of multiple sectors in the national HIV response.

Decentralizing the response

Effective governance of the response ensures that national strategies and mandates are translated into meaningful action in districts and communities. Decentralization of the response helps empower subnational units to implement programmes that meet local needs.

In Ethiopia, service expansion under the country’s Millennium AIDS Campaign has been accelerated through decentralization of service delivery. Building on local leadership and community involvement, 24 000 health “extension” workers were trained to aid households and promote community-health initiatives, including antiretroviral treatment delivery. This focus on decentralized service delivery has been associated with a dramatic increase in the number of individuals receiving antiretroviral drugs—from 8276 in 2005 to 122 243 in 2007.

Although many local governments have taken important action to address HIV over the years, the primary focus of donors on support for national governments has sometimes impeded the ability to implement strong, decentralized HIV responses.³ District-level planning that addressed capacity-building initiatives and resource mobilization for local entities may help overcome some of the historical challenges to an effective decentralized HIV response. (UNDP, 2005.) In the Mbeya region of the United Republic of Tanzania, for example, sustained action and donor support at the subnational level has enabled the region to reach more than 80% of the population with basic prevention services, and to reduce HIV prevalence over the last decade (UNAIDS, 2007b). At the same time as increasing funding to support local governments in the implementation of HIV strategies that address local needs, greater donor assistance

³ Through its Multi-Country HIV/AIDS Program in Africa, the World Bank directed 38% of its HIV-related assistance to support local responses in countries (World Bank, 2007).

is also needed for local communities that are organizing to increase the reach, impact, and accountability of local HIV initiatives.

Grounding the response in human rights

True leaders must often face up to issues that others prefer to ignore. Confronting HIV means addressing issues that make many people uncomfortable, such as human sexuality and drug use. It also requires compassion and effective action with respect to groups that society often prefers to ignore.

While action to address the needs of marginalized populations most at risk remains limited, recent years have nevertheless provided important examples of such leadership, including the launching of a national anti-homophobia campaign in Mexico and the repeal of sodomy laws in the Bahamas. Likewise, the evidence-informed support for needle exchange projects

in countries such as the Islamic Republic of Iran, Malaysia and Viet Nam serve as clear examples of courageous, visionary leadership in the response to HIV.

As the epidemic evolves and the number and range of HIV-related technologies grows, it will be tempting to think of the response solely in technocratic terms. This would be a mistake. Given the realities of HIV—its concentration in marginalized populations, the ways in which it is entwined with human sexuality, and the ways in which its transmission depends on how humans relate to one another—the epidemic is unlikely ever to lend itself to a purely technological solution.

In every country that has achieved major progress in reducing the rate of new HIV infections, the national HIV response has been grounded in the promotion of human rights. Compassion and inclusion remain touchstones for an effective response to the epidemic.

Achieving and sustaining an effective response: a long-term action agenda

- Address documented national needs, and base national action on sound evidence of what works, ensuring full implementation of evidence-informed policies and programmes.
- Plan for the future, by implementing strategic planning and evaluation mechanisms that extend beyond three- and five-year cycles.
- Invest in a truly effective response to HIV, with particular attention to evidence-informed HIV prevention strategies that help contain national epidemics.
- Couple scale-up of programmes with multisectoral leadership to reduce the societal factors that increase HIV risk and vulnerability, including gender inequities, stigma and discrimination, and social marginalization.
- Empower people living with HIV to help lead national HIV responses and involve civil society in the development, implementation, and evaluation of national HIV strategies.
- Harmonize and align the efforts of all stakeholders with nationally driven HIV strategies and priorities, strengthening the quality and flexibility of technical support to build durable national capacity—not only in health systems, but throughout other key sectors, and in both public and private sectors—to sustain a robust and effective HIV response for the coming years.
- Mobilize sufficient financial resources to reach the global target of universal access, putting in place innovative mechanisms to sustain financing for the long-term.