Until recently, AIDS advocacy focused largely on fostering leadership and commitment and mobilizing the financial resources required to mount an effective response to AIDS, globally and within countries. Since 2001, such advocacy has attracted substantial year-after-year increases in funding, making it ever more realistic to hope the AIDS epidemic will be halted and reversed by 2015, the goal set out in the Millennium Declaration (United Nations, 2000). More leadership and more money are still urgently needed, and thus these two areas of focus remain essential, but now there is widespread recognition that a third focus is also vital: making the money work more effectively.

Why is this necessary? As more money has become available, more government, international, civil society and other organizations have been responding to AIDS in many of the low- and middle-income countries most heavily burdened by the epidemic. Often, there have been no mutually agreed-upon strategies or mechanisms guiding, coordinating, monitoring and evaluating their efforts. The result has been duplication, waste and serious gaps in the national AIDS response in many countries. Often, for example, there has been insufficient surveillance to identify the people whose behaviour places them most at risk of infection and consequent failure to reach these people with prevention, treatment, care and support services.

Globally and within countries, as the main players have become increasingly aware of this issue, a central question has arisen in their minds: how can they, individually and collectively, make better use of whatever money may be available to reduce the number of new cases of HIV infection and to reduce the harm done by infection when it occurs and do both these things as quickly as possible? The short answer is that countries must lead and bilateral and multilateral organizations must follow, becoming partners with national governments and other country-level stakeholders.
The framework for international cooperation on country-led development

In 2002, the United Nations Conference on Financing Development in Monterrey, Mexico, concluded that the best way of making optimal use of the available money was through country-led processes through which bilateral and multilateral donors work in partnership with national governments and other country-level stakeholders in mobilizing all the resources available to each country, whether from internal or external sources. Known as the Monterrey Consensus, this end-of-meeting agreement expanded on that conclusion and now provides the framework for international cooperation on development in low- and middle-income countries (United Nations, 2002).

Subsequent meetings have built on the Monterrey Consensus. In February 2003, the High Level Forum on Harmonization issued the Rome Declaration committing donor countries, host countries and bilateral and multilateral institutions to harmonize their policies and procedures (World Bank, 2003). In March 2005, the High Level Forum on Joint Progress toward Aid Effectiveness reviewed results of action to implement the Rome Declaration and issued the Paris Declaration (see box) committing international and national partners to a specific set of harmonization measures.

Guiding principles for country-led action

At the 13th International Conference on AIDS and Sexually Transmitted Infections in Africa, held in Nairobi, Kenya, in September 2003, a working group of country and international representatives developed a set of guiding principles for improving the AIDS response in countries. These principles became known as the “Three Ones” and were endorsed by donor countries, host countries, bilateral and multilateral institutions and international nongovernmental organizations at the Consultation on Harmonization of International AIDS Funding in Washington, DC, United States, in April 2004.

Often, for example, there has been insufficient surveillance to identify the people whose behaviour places them most at risk of infection and consequent failure to reach these people with prevention, treatment, care and support services.
PARIS DECLARATION ON AID EFFECTIVENESS

In March 2005, senior ministers from donor countries and host countries and the heads of bilateral and multilateral institutions met at the High Level Forum on Joint Progress toward Aid Effectiveness hosted by the Development Assistance Committee of the Organisation for Economic Co-operation and Development. Their end-of-meeting agreement (the Paris Declaration) states their resolve to “scale up for more effective aid” by:

- strengthening host countries’ capacity to develop and deliver results-driven national development strategies;
- defining performance standards and measures for host countries’ financial management systems and other systems;
- reforming and simplifying donors’ policies and procedures to make them as cost effective as possible, to reduce unnecessary duplication and bureaucratic burden on countries and to achieve progressive alignment with host countries’ policies and procedures;
- providing more predictable, multi-year aid flows consistent with the sustainable development needs of host countries;
- doing a better job of integrating global initiatives—in areas such as HIV and AIDS—into host countries’ broader development agendas; and
- enhancing both donor countries’ and host countries’ accountability to their citizens and parliaments by making their policies, procedures and activities more transparent.

(UNAIDS, 2004). The “Three Ones” are:

- One agreed AIDS action framework that provides the basis for coordinating the work of all partners;
- One national AIDS coordinating authority, with a broad-based multisectoral mandate; and
- One agreed country-level monitoring and evaluation system.

The Washington meeting called on UNAIDS to act as facilitator and mediator for all the partners in country-led efforts to apply the “Three Ones” and to support integration of monitoring and evaluation into national policies, programmes and reports. It also called on each bilateral and multilateral donor, international aid agency and international nongovernmental organization to play its part. Instead of entering into its own unique relations with its country-level partners, each would harmonize its policies and procedures with country-led ones and coordinate its activities through country-based mechanisms recognized by all the partners. In other words, international cooperation on national action against AIDS would be consistent with the Monterrey Consensus, the Rome Declaration and, more recently, the Paris Declaration.

In March 2005, donor countries, host countries, bilateral and multilateral institutions and international nongovernmental organizations met again, in London at the High Level Forum on the Global Response to AIDS. The meeting—entitled “Making the money work: the ‘Three Ones’ in action”—concluded with a decision to...
In order for all those concerned to work towards common objectives according to common priorities, the Global Task Team recommended that countries ‘mainstream’ AIDS into their national development plans and public expenditure frameworks.

establish a Global Task Team on Improving AIDS Coordination among Multilateral Institutions and International Donors. Its mandate was to develop recommendations for action by bilateral and multilateral institutions to strengthen their support for the country-led response to AIDS (UNAIDS, 2005a).

Global Task Team: building support for the principles

“The “Three Ones” represents our promise to developing nations that we will work with their national plan, under their coordinating authority, using their monitoring and evaluation systems. We certainly want to help them develop these things where assistance is needed, but they must own them.”

Ambassador Randall L. Tobias, United States Global AIDS Coordinator

Global Task Team’s recommendations, presented in June 2005, were aimed mainly at multilateral institutions (UN agencies and the Global Fund to Fight AIDS, Tuberculosis and Malaria) but were also considered applicable to bilateral institutions (UNAIDS, 2005b). In response to the recommendations, the multilateral institutions agreed on:

■ a division of labour (UNAIDS, 2005c);
■ a Consolidated UN Technical Support Plan (UNAIDS, 2005d); and
■ a Global Joint Problem-Solving and Implementation Support Team.

The First “One”: an agreed AIDS action framework

In order for all those concerned to work towards common objectives according to common priorities, the Global Task Team recommended that:

■ countries engage all key stakeholders in the development of annual priority AIDS action plans that are evidence-based, multisectoral, prioritized, fully budgeted and permit clear and simple monitoring and evaluation. These plans should clearly delineate the roles and responsibilities of all stakeholders, stating who does what, when and where. They should detail, prioritize and
budget for any needs for technical support and for building capacity of human resources and infrastructure;
- countries ‘mainstream’ AIDS into their national development plans and public expenditure frameworks;
- donors comply with the Paris Declaration on Aid Effectiveness and shift their support from short-term projects to sustained programmes;
- multilateral institutions, including UN agencies, work with countries to develop internationally recognized standards for annual priority AIDS action plans plus a simple self-assessment tool. They should also assist with the simple and rapid development of plans through processes that do not interfere with continuing implementation.

As outlined below, countries generally face five main challenges in applying the first “One”: (i) facing the facts and countering stigma and discrimination; (ii) engaging all key stakeholders; (iii) gathering and analysing strategic information; (iv) translating AIDS action frameworks into annual priority action plans with budgets; and (v) mainstreaming AIDS strategies into national development plans and expenditure frameworks.

FACING THE FACTS AND COUNTERING STIGMA AND DISCRIMINATION
A recent analysis of the experience of Asian countries found that the most successful programmes to prevent the spread of AIDS have three features in common. First, they face the facts about how HIV is mainly transmitted in their region, i.e. by anal or vaginal penetration without condoms or by injecting drugs with contaminated needles and syringes. Second, they provide ready access to information, services and supplies on a scale large enough to have an impact on the rate of transmission among people who participate in these activities by reaching most men who have sex with men, injecting drug users, sex workers and men who live and work in isolated settings such as prisons, mines and military camps. Third, they provide secure and supportive social and political environments where people most at risk feel safe taking advantage of the information, services and supplies on offer (Monitoring the AIDS Pandemic, 2004).

When the AIDS epidemic emerges in a country, it tends to appear first among people whose behaviours are the objects of traditional taboos, social prejudices and general embarrassment and may even be illegal, or it may simply appear among the young, who often defy behavioural norms. One result is that people in these key populations do their best to remain invisible to disapproving eyes. If countries do not face the facts and respond appropriately at this early stage, they may soon find themselves with concentrated epidemics, where there is a high prevalence of HIV among these populations. Since these populations are not isolated but overlap and interact sexually with others in society, countries may eventually find themselves with generalized epidemics, with a high prevalence of HIV among the whole population.

Country-specific information (including data from good surveillance of HIV disease and behaviours associated with the disease) and education that counters ignorance, stigma and discrimination are essential elements of any effort to mobilize the public and their leaders—not only to start a realistic response to AIDS but also to keep accelerating, adjusting and sustaining the response until the epidemic is halted and reversed.
ENGAGING ALL KEY STAKEHOLDERS

If key stakeholders are left out of processes for developing, reviewing and updating the national AIDS plan, it is unlikely that the plan will be comprehensive and well balanced, taking all stakeholders’ legitimate concerns into account and giving them fair weight. It is also unlikely that all key stakeholders will be committed to participating in implementing the plan or accepting it as an instrument that should guide their efforts. The key stakeholders include:

- national government ministries responsible for key sectors of socioeconomic development, including not only ministries of health but also other ministries, such as those responsible for finance, national planning, district and local affairs, education, employment and labour, social services, justice, defence and agriculture;
- provincial, district and local government authorities;
- civil society organizations (including faith-based organizations) at the international, national and subnational levels, including those involved in delivering AIDS-related services;
- individuals and networks of people living with HIV and people at high risk of infection, including youth, women, men who have sex with men, injecting drug users, sex workers, people with sexually transmitted infections, men who live and work in isolated settings, mobile populations (migrant workers, refugees and displaced people, asylum seekers and people who have been trafficked);
- the private sector, from the largest international corporation to the smallest local business and from large labour unions to small workers’ associations; and
- bilateral and multilateral donors, international institutions and philanthropic foundations.

In its 2004 UNAIDS Annual Country Report survey, UNAIDS Country Coordinators assessed the degree of participation of many of the main categories of stakeholder in the review and update of national AIDS plans. Figure 11.1 shows the results, indicating that the

![Stakeholder participation in development of national AIDS plans in 79 countries, 2004](image-url)

Source: UNAIDS (2006). From advocacy to action: a progress report on UNAIDS at country level. UNAIDS.
highest degrees of participation were by UN agencies, followed by associations of people living with HIV and donors. The lowest degrees of participation were by faith-based organizations, the private sector and women’s groups.

GATHERING AND ANALYSING STRATEGIC INFORMATION

Any effective plan against AIDS is based on reliable information about: (i) the people infected and affected by HIV; (ii) the conditions and behaviours that put those people at risk; (iii) the resources available for the response; (iv) current efforts to intervene with prevention, treatment, care and support; (v) the results of those efforts; and (vi) what other countries are doing that may be worth adapting.

How countries are meeting the challenge of gathering the evidence on which to base their plans is discussed at greater length in the Third “One” section later in this chapter.

TRANSLATING AIDS ACTION FRAMEWORKS INTO ANNUAL ACTION PLANS

While an overall philosophy and broad set of aims can be a useful beginning, a national AIDS plan may amount to little more than a statement of good intentions unless it also outlines firm commitments to specific objectives and milestones for achievement. For the plan to be effective,

IN LATIN AMERICA, UNRELIABLE DATA HAVE LED TO NEGLECT OF MEN WHO HAVE SEX WITH MEN

Annual spending estimates provided by the Regional AIDS Initiative for Latin America and the Caribbean confirm that many Latin American countries make little effort to provide AIDS-related services that address the needs of men who have sex with men (SIDALAC, 2005). In fact, many Latin American countries have done little sentinel surveillance to provide reliable evidence on which to base their HIV estimates on prevalence. Instead, they have relied on passive surveillance, using reports from hospitals and clinics of people who have presented with symptoms and have been subsequently tested. Since people often have no symptoms until years after they are infected, such records do not provide up-to-date data. Neither do they provide reliable evidence of the mode of transmission in countries where men having sex with men is strictly taboo. Often, health professionals are too embarrassed to ask the right questions and, even if asked, men are afraid to provide the right answers (PAHO et al., 2005).

Recently reported findings of a study that carried out surveillance between 1999 and 2002 in a number of cities in the Andean countries found that HIV prevalence among men who have sex with men was as high as 23.7% in a Bolivian city, 19.7% in a Columbian city, 27.9% in an Ecuadorian city and 13.7% in a Peruvian city and averaged 12.0% in all cities covered by the study (Montano et al., 2005). Surveillance in the capital cities and seaports of Central America between 2000 and 2002 found HIV prevalence among men who have sex with men averaging 17.7% in El Salvador, 11.5% in Guatemala, 13.0% in Honduras, 9.3% in Nicaragua and 10.6% in Panama (PASCA et al., 2003).
While an overall philosophy and broad set of aims can be a useful beginning, a national AIDS plan may amount to little more than a statement of good intentions unless it also outlines firm commitments to specific objectives and milestones for achievement.

these objectives and milestones must be translated into annual AIDS action plans with budgets, assigning responsibilities and tasks and allocating resources to all partners that are called on to act.

In 2004, Indonesia had a population of more than 220 million people and more than 100,000 were infected with HIV. It was in the early stages of mobilizing its comprehensive response to an emerging and rapidly spreading AIDS epidemic largely concentrated among injecting drug users, except in Papua province, where the epidemic was generalized. Since the 1990s, Australia and the United States had been providing support for capacity-building in national and provincial AIDS commissions and in the ministry of health and also supporting the work of many nongovernmental organizations, with emphasis on outreach to populations at greatest risk of infection. However, the national government had allocated an annual budget of only US$ 10.6 million for implementation of the country’s National AIDS Strategy. Despite public commitments by six ministers and six governors of the most affected provinces, the small budget meant the National AIDS Commission was unable to take full advantage of this political support by mobilizing the ministries and provinces for comprehensive action.

A breakthrough came in June 2004 when the Global Fund approved a grant of US$ 65 million. In late 2004, the Country Coordinating Mechanism was revitalized by an internal task force. This process saw the establishment of a Country Coordinating Mechanism Secretariat that now shares office space and other resources with the National AIDS Commission Secretariat. A further grant of £25 million (US$ 43.9 million), from the United Kingdom’s Department for International Development, established the Indonesian Partnership Fund for HIV/AIDS to support capacity-building of the National AIDS Commission Secretariat and implementation of the National AIDS Strategy. Now, for the first time, Indonesia’s National AIDS Commission and its Secretariat are able to translate the National AIDS Strategy into action plans with supporting budgets for key partners. In early 2006, four regional meetings launched a minimum response package for 100 priority districts and cities across the country.
MAINTREAMING AIDS STRATEGIES INTO NATIONAL DEVELOPMENT PLANS AND EXPENDITURE FRAMEWORKS

A UNAIDS survey of 68 low- and middle-income countries with Poverty Reduction Strategy Papers showed that 48 had included AIDS strategies in their papers. These papers are prerequisite to grants, interest-free credits and low-interest loans from the World Bank and are among the main development instruments of most low- and middle-income countries heavily burdened by AIDS. Other instruments include National Development Plans, Medium Term Expenditures Frameworks and the annual plans and budgets of national government ministries and their district and local counterparts. Failure to include AIDS strategies in Poverty Reduction Strategy Papers is a strong indication of failure to mainstream the national response to AIDS into the regular work of all sectors of government at the national, district and local levels. (It also indicates failure to mainstream the national response in public-sector workplaces, since providing AIDS-related services to employees and their families is a major contribution all employers can make to the national response.)

The World Bank, UNDP and UNAIDS Secretariat are currently engaged in a joint project to build the capacity of countries to mainstream their response to AIDS into their Poverty Reduction Strategy Papers. Assessments in Ethiopia, Ghana, Mali, Rwanda, Senegal, the United Republic of Tanzania and Zambia have collected views from key stakeholders and produced ‘issue’ papers outlining progress and identifying challenges for each country. A joint regional workshop for the seven countries used these issue papers as the basis for action plans to mainstream their AIDS response into their Poverty Reduction Strategy Papers through 2006 and 2007. During 2006 and 2007, additional rounds of assessment, issue paper production and action plan development will build mainstreaming capacity in other countries with Poverty Reduction Strategy Papers in Africa, the Asia-Pacific region, Latin America and the Caribbean, eastern Europe and the Commonwealth of Independent States.

In December 1997, after taking part in a symposium at the Xth International Conference on STD/AIDS in Africa, held in Abidjan, Côte d’Ivoire, mayors and municipal leaders from 10 countries

WHAT DOES IT MEAN TO ‘MAINSTREAM’ AIDS?

Mainstreaming AIDS has been broadly defined as “a process that enables all development actors to address the causes and effects of AIDS in an effective and sustained manner, both through their usual work and within their workplace” (UNAIDS, 2005d). For example, in August 2004, representatives of the four major faith-based groups (Roman Catholic, Evangelical, Islamic and Orthodox) in Ethiopia committed themselves to mainstreaming AIDS into their spiritual and development endeavours. Governments have a particular responsibility, however, to lead the way in all sectors (such as health, education and justice) and at all levels (national, district and local).
in sub-Saharan Africa issued the Abidjan Declaration stating their commitment to address AIDS in their communities and to work in solidarity with each other and in partnership with national, international and public and private stakeholders. At the Africities Summit in 1998, also in Abidjan, they launched the Alliance of Mayors and Municipal Leaders on HIV/AIDS in Africa, which now has ‘chapters’ in 13 countries. Before Swaziland’s chapter of this alliance was established in 2001, there was no organized local government response to AIDS in the country. Now the governments of all 12 major municipalities, with around 25% of the country’s population, collaborate with the National Emergency Response Council on HIV and AIDS and are in partnership with more than 25 national and international organizations on building capacity and scaling up prevention, treatment and care for municipal residents (AMICAALL, 2006).

A comprehensive national HIV and AIDS response must also include marginalized populations such as refugees and internally displaced people. Integrating these populations into existing HIV programmes for surrounding host populations is complementary to the national effort and makes public health sense as these populations often mix and interact closely. Uganda and Zambia have integrated host and refugee HIV programmes, leading to improved infrastructure of district hospitals (UNAIDS/UNHCR, 2005).

The Second “One”: a national AIDS coordinating authority

The Global Task Team recommends that:

- national AIDS coordinating authorities take the lead and bilateral and multilateral institutions harmonize their policies and activities with those of the national AIDS coordinating authorities;
- when requested by countries, the Joint UN Team on AIDS support national AIDS coordinating authorities in building their capacity to develop AIDS action plans, to coordinate multi-stakeholder implementation and to monitor and evaluate results;
- when requested by countries, multilateral and bilateral partners assist other stakeholders to convene under the umbrella of the national AIDS

The World Bank, United Nations Development Programme and UNAIDS Secretariat are currently engaged in a joint project to build the capacity of countries to mainstream their response to AIDS into their Poverty Reduction Strategy Papers.
Fostering leadership has been a major focus of AIDS advocacy since the epidemic emerged 25 years ago, when people living with HIV or at high risk of infection became leaders themselves and began demanding leadership and specific commitment from politicians and other stakeholders.

coordinating authority in teams for problem-solving and action on human-resource capacity development and other matters;
■ when requested by countries, the Global Fund, World Bank and UNAIDS Secretariat support efforts to address problems and clarify relations between national AIDS coordinating authorities and Country Coordinating Mechanisms and disseminate examples of good practice.

Typically, a national AIDS coordinating authority includes both a governing council and a secretariat or some other entity acting under the council’s oversight and direction. It derives its authority from three sources: (i) from government, which requires political leadership, commitment and delegation of authority through laws, policies and procedures; (ii) from its own competence, which requires adequate budgets, qualified staff and access to advice, training and technical support; and (iii) from stakeholders who recognize its mandate from government and its competence.

Stakeholders will only have confidence in a national AIDS coordinating authority if they feel they are adequately consulted and otherwise involved in mutually beneficial relationships with the authority. To build such relationships with all key stakeholders, the national AIDS coordinating authority needs to build or encourage the building of structures (e.g. committees or partnership forums) as vehicles for communication of information and ideas and for coordination of efforts. It may also require specialized staff, skilled in attracting, sustaining and coordinating the involvement of hundreds of stakeholders. In addition, it requires stakeholder leadership, commitment and capacity to be meaningfully involved.

The nature and quality of the existing authorities vary vastly, however, and there is room for improvement even in the best of them. Countries face four main challenges in applying the second “One”: (i) fostering leadership and commitment; (ii) establishing the legal and policy framework; (iii) developing structures for engagement of stakeholders; and (iv) building partnerships with international development agencies. Learning from other countries’ experiences and actively collaborating with them are
among the ways of meeting these challenges.

**FOSTERING LEADERSHIP AND COMMITMENT**

The degree of stakeholder involvement, as discussed earlier in this chapter, is a fair measure of the degree of leadership, not only at the highest levels of government but also within line ministries, district and local authorities and other stakeholder groups. Fostering leadership has been a major focus of AIDS advocacy since the epidemic emerged 25 years ago, when people living with HIV or at high risk of infection became leaders themselves and began demanding leadership and specific commitment from politicians and other stakeholders.

An example can be seen in the Asia Pacific Leadership Forum on HIV/AIDS and Development. Launched in 2002, it has proved effective in supporting and strengthening political and civil society leadership within 33 countries and at subregional and regional levels. The forum is guided by a Steering Committee of prominent leaders—for example, the former prime ministers of India and Thailand, the former First Lady of Papua New Guinea and the Chief of China’s Institute of Viral Disease Control and Prevention. It has developed a number of advocacy tools, including a book featuring statements from prominent political and civil leaders in the region which has been translated into many of the region’s languages. It also hosts advocacy events for leaders in different fields, including the media and faith-based organizations (APLF et al., 2005). Over the past three years, the Asia Pacific Leadership Forum has worked with the Pacific Islands Forum to develop the Pacific Regional Strategy on HIV/AIDS (2004–2008) and the Pacific Regional Strategy Implementation Plan, which was approved in October 2005. Regional cooperation on fostering leadership and commitment and developing a common strategy has proved to be a cost-effective way for the 22 small island nations of the Pacific region to respond to AIDS (Secretariat of the Pacific Community, 2005).

**ESTABLISHING THE LEGAL AND POLICY FRAMEWORK**

In general, a national AIDS coordinating authority will be strengthened if its mandate to lead and coordinate the national AIDS response is specified in law and if the law also specifies its relationships with the country’s most senior authorities (e.g. prime minister, cabinet committee and parliament) and with ministries. Without such a specific mandate, a national AIDS coordinating authority may find itself overridden or undermined by, for example, senior ministries with their own AIDS agendas.

A national AIDS coordinating authority will also be strengthened by a national AIDS policy laying out the government’s broad aims (e.g. protecting public health and reducing harm associated with HIV) and specifying its attitudes towards such matters as respecting human rights, protecting confidentiality and assisting with harm reduction even in the case of behaviours that may be illegal (e.g. injecting drug use and sex work). Related legislation should be reviewed and reformed to ensure that it is in accordance with the national policy. The International Labour Organization, for example, advises governments on the review and, if necessary, redrafting of labour legislation to include HIV and AIDS, with particular attention to preventing discrimination in employment.

The legislation must be carefully crafted, however, to ensure that the national
Civil society organizations have understood that ensuring their engagement will require leadership on their part and they have been asserting this leadership to ensure that their interests are taken into full consideration.

AIDS coordinating authority is an active, well-functioning body. In Mozambique, a May 2000 Ministerial Decree established what promised to be a powerful National AIDS Council, with the Prime Minister as chair, the Minister of Health as vice-chair, representatives from the ministries of finance, planning and development, education, women and social action and youth and sports, plus representatives from parliament, civil society organizations, universities and the media. When a multi-agency advocacy mission visited Mozambique in March 2005, however, it found that the National AIDS Council had not met for more than a year. As a result of the visit, the council met twice in April 2005, reviewed the composition of its board and agreed to involve provincial leaders and decentralize the national response to provinces and communities. In November 2005, a “Three Ones” assessment mission found that there had been further action to revitalize the council. In response to complaints that the civil society

**Prime Minister of Viet Nam Leads a Multi-Ministry Response**

In March 2004, Viet Nam’s Prime Minister approved the National Strategy on HIV/AIDS Prevention and Control, which extends to 2010 and also establishes a vision to 2020. It was developed by the Ministry of Health, one of three ministries that serve as secretariats to the National Committee for AIDS, Drugs and Prostitution Prevention and Control, a committee chaired by the Prime Minister. The Strategy calls for coordination by the Ministry of Health and action by five other ministries. In December 2004, the Prime Minister declared that 2005 would be “the year for AIDS programme implementation” and called for all ministries to develop AIDS plans for their sectors. Also in 2004, the Prime Minister initiated development of the 2006–2010 Socioeconomic Development Plan, identifying AIDS as a major issue to be addressed in the plan. In addition, he asked the Communist Party to become active in AIDS through the Fatherland Front (a coalition which mobilizes society), the Viet Nam Women’s Union and the Viet Nam Youth Union (UNAIDS, 2005e).
representatives were appointed by government, a process has been established whereby civil society umbrella groups appoint their own representatives. The umbrella groups include a national network of civil society organizations, a national network of people living with HIV, the Mozambican Christian Council, ECOSIDA (an organization representing businesses against AIDS) and the Organization of Mozambican Workers. With its new, more committed membership, the National AIDS Council has been meeting every 45 days and has become much more active (Barcellos, 2005).

A “Three Ones” assessment mission to Zambia in early 2005 found that the 2002 act of parliament establishing the National AIDS Council had created an organizational structure strong at its base, with Provincial and District AIDS Task Forces that facilitated involvement of a broad range of government agencies, civil society organizations and private businesses. However, it had weaknesses at the top, including a largely inactive National AIDS Council, whose authority was undermined by the fact that the Director-General of the National AIDS Council Secretariat could bypass the council and report directly to the Cabinet Committee of Ministers on HIV/AIDS. The mission also noted that there was a draft National HIV/AIDS Policy outlining a broad vision for the national response but it was insufficiently specific to provide useful guidance to the review in progress and for updating the national AIDS plans (Roseberry et al., 2005). The draft was subsequently amended and the policy adopted by Zambia’s parliament in June 2005 was more specific in identifying measures for realization of the vision. It also clarified the legal and institutional framework.

DEVELOPING STRUCTURES FOR ENGAGEMENT OF STAKEHOLDERS

Since September 2003, when the 13th International Conference on AIDS and Sexually Transmitted Infections in Africa formulated the “Three Ones” principles, countries have been taking steps to improve stakeholder engagement. Much of the drive for this movement has come from civil society organizations. In the past, they have been insufficiently involved in the mechanisms for developing and implementing national AIDS plans and in monitoring and evaluating results. They now see that the “Three Ones” principles, with their emphasis on a multisectoral response, present strong arguments for greater involvement.

Civil society organizations have understood that ensuring their engagement will require leadership on their part and they have been asserting this leadership to ensure that their interests are taken into full consideration. For example, in early 2005, the International HIV/AIDS Alliance and International Council of AIDS Service Organizations collaborated on a discussion paper outlining the opportunities and challenges presented by the “Three Ones.” At a joint UNAIDS and civil society planning meeting in Recife, Brazil, in September 2005, it was agreed that civil society organizations would play a role in monitoring progress on the 2001 UN General Assembly’s Declaration of Commitment on HIV/AIDS and would prepare their own reports on progress in selected countries, to be considered alongside the reports submitted by countries (UNAIDS, 2005f).

Civil society organizations and other key stakeholders are often not sufficiently engaged in developing national AIDS plans and other processes, though there are signs
BRAZIL PROVIDES FOR BROAD STAKEHOLDER ENGAGEMENT

Brazil is often cited as a model of good practice when it comes to responding to AIDS. One key to Brazil’s success is that the country’s national AIDS response is guided by three forums and a number of advisory committees involving a broad range of stakeholders, including more than 1800 civil society organizations.

Meeting four times a year, the National AIDS Commission has representatives from universities, research institutions, faith-based organizations, private enterprise, labour organizations, civil society, national government ministries and agencies from the federal district and state and local government. The Articulating Commission for Social Movements, which also meets four times a year, is a forum for people living with HIV and populations at risk, including indigenous people, other racial minorities, women, young people, self-identified gay men, transvestites and injecting drug users. The third forum coordinates activities at the state and local level. In addition, there are advisory committees on specialized areas such as prevention, support, vaccine research and the media.

The three forums and advisory committees are all involved in regular reviews and updates of the national AIDS plan and their involvement means that they are strongly committed to seeing that it is implemented. Although the structure of the plan is strong, the National AIDS Commission recognizes that the plan needs to be extended to rural states and communities where recent surveillance gives reason for concern. In Brazil, as everywhere else, building, sustaining and improving the structure for engagement will always be a continuing process.

of improvement in terms of stakeholder engagement in many countries. They have been doing this through such measures as making their national AIDS councils more broadly representative and adding or strengthening committees and partnership forums through which networks of stakeholders are engaged in developing, reviewing and updating national AIDS plans and coordinating their efforts to implement the plans and monitor and evaluate the results.

Each country has to discover the mechanisms that suit its own circumstances best but, at the same time, each country can learn from what other countries are doing.

BUILDING PARTNERSHIPS WITH INTERNATIONAL DEVELOPMENT AGENCIES

In March 2005, before establishing the Global Task Team, the High Level Forum on the Global Response to AIDS considered a report describing problems countries often experience in their relations with donors. They include: (i) limited donor participation in the development of national AIDS plans; (ii) limited harmonization of policies and procedures among donors and between donors and national AIDS coordinating authorities; (iii) lack of transparency, with the result that donors’ policies, procedures and decisions are not always apparent; (iv) donors’ tendency to follow their own
agendas rather than agendas set by countries; (v) donor preference for supporting projects rather than continuing programmes; (vi) donor preference for using their own financial mechanisms rather than government mechanisms; and (vii) high transaction costs resulting from donors’ policies and procedures (UNAIDS, 2005g).

Many countries have been finding their own unique solutions. In 2005, for example, the Government of the United Republic of Tanzania combined the Country Coordinating Mechanisms with other financial coordinating mechanisms to form the Tanzania National Coordinating Mechanism. The Secretariat of the Tanzania Commission for AIDS doubles as the Secretariat for the Tanzania National Coordinating Mechanism, which is chaired by the Permanent Secretary of the Prime Minister’s Office. Represented on the Coordinating Mechanism are the ministries of health and finance, Office of the President, civil society organizations including faith-based organizations, people living with HIV, academia, the Trade Union Congress, the AIDS Business Coalition and the Media Council of Tanzania. Also represented are the Development Partners Group (an umbrella group representing a number of bilateral donors), the United States President’s Emergency Plan for AIDS Relief and UN agencies (Global Fund, 2005).

After the Global Task Team produced its recommendations in June 2005, the Global Fund commissioned an independent assessment of its proposal development and review process (European Health Group, 2006) and, with the World Bank, a study comparing the strengths of the two institutions and how they might complement each other better in their joint support for country programmes (Shakow, 2006). The two resulting reports contained several pages of recommendations: the principal recommendations can be broadly summarized as follows.

- Both organizations should make stronger efforts to support the “Three Ones” by working together on preparing, budgeting and implementing country-specific action plans. A specific area of duplication they should examine is the existence of Country Coordinating
THE GLOBAL FUND TO FIGHT AIDS, TUBERCULOSIS AND MALARIA EVALUATES AND IMPROVES COUNTRY COORDINATING MECHANISMS

In 2005, the Global Fund commissioned an independent assessment of the composition and performance of Country Coordinating Mechanisms, using an agreed set of tools and measures and requiring evidence in the form of verified documentation (see ‘Civil society’ chapter). The results covered 82 Country Coordinating Mechanisms (77% of 106 surveyed) and found that their members were broadly representative of the groups engaged in countries’ responses to the three diseases within the remit of the Global Fund. On average, 50% of members were drawn from outside of government and 71% of Country Coordinating Mechanisms had members representing people living with the diseases. The assessment also revealed some weaknesses, including the following:

- only one in five members had been selected through a transparent, well-documented process;
- only about half of Country Coordinating Mechanisms had made calls for proposals publicly available; and
- less than half had published their decisions and information on the proposals approved.

In May 2005, immediately after the assessment, the Global Fund released revised guidelines and many Country Coordinating Mechanisms introduced reforms to address their weaknesses and comply with the guidelines. The Global Fund is now incorporating Country Coordinating Mechanism self-assessment into routine grant management with a view to identifying weaknesses, taking steps to correct them and reporting on progress.

Mechanisms separate from national AIDS coordinating authorities and their financial mechanisms.

The Global Fund should clarify what it will and will not do. Its focus should be on direct financing of prevention and treatment, rather than on direct technical support and far-ranging and diverse systematic and multisectoral support, which is provided by the World Bank, other UNAIDS Cosponsors and bilateral institutions.

The World Bank, in conjunction with UN agencies, should focus on the systematic health-sector capacity-building that is fundamental to progress against AIDS and other diseases. The World Bank should link health-sector capacity-building to broader macroeconomic and budgetary aims. It should also help governments be more strategic and selective in setting priorities for AIDS and other health-related activities, to take best advantage of their limited capacities.

The Global Task Team’s recommendations invite countries to take the lead on such matters by requesting, for example, reviews of the relationship between their national AIDS coordinating authorities, Country Coordinating Mechanisms and the main financial mechanisms used by their national governments and their various ministries. Meanwhile, multilateral donors are continuing to review their policies and procedures with a view to serving countries better.
The Global Task Team recommends that:

■ multilateral and other international institutions assist national AIDS coordinating authorities in the strengthening of country-wide monitoring and evaluation systems and other systems that facilitate oversight and problem-solving;

■ national AIDS coordinating authorities, multilateral and other international institutions increase the role of civil society and academic institutions in monitoring and evaluation, including the gathering of data from marginalized communities and the critical analysis of all data;

■ participatory reviews of national AIDS plans and programmes include reviews of the performance of all stakeholders, including country-based stakeholders and multilateral and other international institutions.

National AIDS coordinating authorities and all stakeholders need reliable information to ascertain which programmes and services are required to provide HIV prevention, treatment, care and support. Once these programmes and services are in place, they need reliable information to monitor their outputs (e.g. the number of people provided with preventive education) and outcomes (e.g. changes in the number of people using condoms) and longer-term impacts (e.g. changes in HIV prevalence). The third “One,” an agreed country-level monitoring and evaluation system, points to the most efficient and effective way of gathering, analysing and reporting this information.

Effective monitoring and evaluation requires gathering and analysing data from a variety of sources. Data need to include information on the policy environment and on financial resource flows, as well as on the nature and quality of services, who provides the services, who uses them, frequency of use, costs and outcomes. Programme monitoring requires the establishment of indicators for measuring progress and then regular reviews to determine progress on implementation and outcomes. Programme evaluation involves a more detailed
analysis to determine the merit of programmes and provide explanations of why particular outcomes have or have not occurred. Programme monitoring and evaluation can be performed at all levels, from a particular facility in a community to a programme covering a whole community, district or country. Programme evaluation, or lack thereof, is the weakest component of most monitoring and evaluation systems.

Surveillance is another essential component of effective monitoring and evaluation. It provides data on HIV and AIDS prevalence in the general population and among particular populations and on associated infections, behaviours and knowledge. It also monitors trends over time. These data help both to identify needs for programmes and services and to identify the outcomes and impacts of those services.

All the various data produced by an effective monitoring and evaluation system are referred to as strategic information. Reliable and comprehensive strategic information provides the basis for effective planning and implementation and also for increasingly effective monitoring and evaluation to provide more reliable and comprehensive strategic information.

THE CURRENT STATE OF MONITORING AND EVALUATION
UNAIDS circulates a National Composite Policy Index questionnaire to guide countries when they report on their progress towards achieving the goals outlined in the 2001 Declaration of Commitment on HIV/AIDS. For the first time, the Index circulated for the 2005 progress reports had a significant focus on monitoring and evaluation. Of countries that responded:

- 51% reported having made modest to considerable progress on monitoring and evaluation since 2003, while 43% rated themselves average or below average for monitoring and evaluation;
- 50% had developed monitoring and evaluation plans and most of these had a dedicated monitoring and evaluation budget and were developing relevant human resources capacity, either within monitoring and evaluation units, departments, committees or working groups;
- Not surprisingly, that 50% was more likely than other countries to have multistakeholder agreement on sets of monitoring and evaluation indicators and also to have functional data management systems, more use of the data by stakeholders and more sharing of data among stakeholders;
- 54% had established central databases on HIV and AIDS; 85% had established Health Management Information Systems and 50% had established both. In addition, 63% of countries had Education Information Systems. These are all important tools enabling the gathering, analysis and reporting of data and ready access to that data by all stakeholders; and
- 49% reported moderate to high levels of data sharing between their governments and bilateral and multilateral institutions, including UN agencies. While this shows an encouraging trend, it also shows need for improvement so that governments have access to all the data they need for evidence-based decision-making.

The data reported by these countries contributed to monitoring of their progress on all of the “Three Ones.” Ninety percent reported that they had one national AIDS action framework,
85% had one national AIDS coordinating authority and 50% had one national monitoring and evaluation plan. The mere existence of these “Ones” is no indication of how well they function and the data confirm that considerably more attention needs to be paid to strengthening countries’ monitoring and evaluation systems.

One country commented, “Monitoring and evaluation of HIV and AIDS activities is an area that has lagged among the three components of the “Three Ones” principles apparently because many agencies implementing various activities have no legal requirement to report to the National AIDS Council and multiple powerful donors require different monitoring and evaluation reports.” Another stated, “Many stakeholders still consider that monitoring and evaluation for HIV programmes is the prime responsibility of a national coordinating body. However the implementation of the M&E framework will require the mobilisation of resources at all levels and amongst many stakeholders: this includes the M&E capacity of civil society and faith-based organisations as well among relevant ministries.”

**COMMUNITY PARTICIPATION IN MONITORING AND EVALUATION**

The Collaborative Fund for HIV Treatment Preparedness is a global project that aims to increase community participation in stemming the tide of the AIDS epidemic, with participating sites around the world (Figure 11.2). As part of the project, participating groups encourage each other to monitor and evaluate the implementation of their programmes. They hold regional training workshops and have a web site that provides monitoring and evaluation support to all community-based participants in the project. Web site features include: (i) a non-technical introduction to evaluation basics; (ii) a glossary of common evaluation vocabulary; (iii) indicators for measuring project progress and results;

![Figure 11.2](image-url)
THE GLOBAL FUND’S PERFORMANCE-BASED FUNDING APPROACH

The Global Fund manages the flow of its grants by using the results achieved by grant-supported programmes. The Global Fund uses performance-based funding to hold programmes to the commitments made in their grant proposals.

Successful achievement of results releases the next stage of financing. Programmes that perform well are given money at an accelerated rate. Programmes that perform poorly are given money at a slower rate and may be given less, so unused money can be transferred to better performing programmes that could use more support. Special circumstances are taken into consideration at each stage, as are self-assessments that identify requirements for more technical assistance. In general, however, the flow of funding is determined by the speed of implementation and proven results.

Performance-based funding has two core requirements: (i) monitoring and evaluation; and (ii) transparency. Transparency ensures that information on grant implementation can be used by decision-makers at all levels everywhere, whether engaged as partners in grant-supported programmes or as interested observers from within or outside the countries where the programmes are based.

Countries are proving that performance-based funding works. To date, 80% of grant-supported programmes have shown documented results by month 18 of a 60-month period for each grant. The poorest countries are just as successful as others, as long as results are measured against strategies and targets they set themselves and as long as grants cover needs for technical assistance they identify themselves. In several countries—including Ethiopia, Honduras, Kenya and the Lao People’s Democratic Republic—performance-based funding proves to be providing crucial incentives to accelerate implementation.

(iv) technical assistance in creating and using common evaluation tools; (v) discussion forums; (vi) answers to frequently asked questions; and (vii) a direct e-mail connection to monitoring and evaluation professionals who can provide technical support.

BILATERAL AND MULTILATERAL SUPPORT FOR MONITORING AND EVALUATION

The Monitoring and Evaluation Reference Group, coordinated by UNAIDS, brings together technical experts and representatives from bilateral and multilateral institutions and countries, including the countries’ HIV programme managers and
directors of monitoring and evaluation units. The Monitoring and Evaluation Reference Group harmonizes activities across countries by, for example, creating standardized indicators, promoting the use of particular methods and developing training modules. In addition, a number of bilateral and multilateral institutions—for example, the United States’ Centers for Disease Control and Prevention and UNAIDS—deploy technical staff in over 60 countries to support their monitoring and evaluation efforts. These professionals work directly with countries’ professionals and support, among other things, harmonization and coordination of all stakeholders’ monitoring and evaluation activities within countries.

As a result of these efforts, a number of standard monitoring and evaluation indicators have been developed, but there is still much work to be done in harmonizing and simplifying the indicators used by the many different stakeholders involved in the AIDS response in countries.

**MAPPING AND TRACKING RESOURCES**
Chapter 10 discusses the significant mismatch in most countries between where financial resources are most required to mount an effective response to HIV and where financial resources are actually spent. Most countries still need to strengthen the use of strategic information to identify the financial and human resources and infrastructure they already have and to estimate where more resources are required.

Many countries fail to carry out surveillance that would tell them which populations are most in need of services and even when data from such surveillance are available, many countries fail to select such populations as beneficiaries of services. Often this is a result of the difficulty of accessing the key populations at higher risk and the weaknesses in policies (including human rights legislation) and procedures that ensure the delivery of services to people most in need of services. Clearly, the flow of limited resources should be managed so that they go to where they are most needed but often, government and donor policies intervene, so some key populations at higher risk are hardly served at all.

In 1995, the World Bank asked the Mexican Health Foundation to be the executing agency for the Regional AIDS Initiative for Latin America and Caribbean (SIDALAC). In 1996, after consulting with national AIDS coordinating authorities and securing funding from the European Commission, the Regional AIDS Initiative for Latin America and Caribbean initiated a mechanism for tracking AIDS spending in the region’s countries. Its approach was to encourage and support countries in establishing National AIDS Accounts, a process that required time and patience but that began producing good annual estimates of spending on AIDS in the health sector in 1999. Subsequently, with help from the Regional AIDS Initiative for Latin America and Caribbean, a similar approach was taken in West Africa. The best available data tracking spending over a number of years now come from the regions of Latin America and the Caribbean and West Africa.

The UNAIDS Global Resource Tracking Consortium and its many members now track resources on a global level. In the course of doing so, they advocate for and support better resource tracking by countries. In 2005, the Consortium launched a
new initiative to promote and support National AIDS Spending Assessments. Whereas the National AIDS Accounts focused on the health sector, the spending assessments are much broader and cover a range of sectors where action against AIDS contributes to the overall national AIDS response. The approach is the same as that taken by the Regional AIDS Initiative for Latin America and Caribbean: instead of commissioning one-off assessments by consultants, countries are supported in capacity-building so their AIDS accounting procedures become continual and sustainable.

More than 60 countries now participate in this initiative and some have already produced preliminary results. Where these assessments have been completed, countries are able to identify sources and amounts of financing (out-of-pocket spending, public spending, bilateral and multilateral donations and private philanthropy), spending by different service providers (in the health sector and in other areas, broken down into salaries, commodities, travel, etc.) and spending by type of programme (prevention, care, social mitigation, programme support) and by beneficiary (harm reduction to injecting drug users, life-skills training to young women, etc.). The results already achieved by the new initiative suggest that the situation could improve rapidly if bilateral and multilateral institutions and national AIDS coordinating authorities all support the initiative.

For the 2005 review of progress on the 2001 Declaration of Commitment, 82 countries reported their domestic public expenditure on AIDS. These estimates were based on continuing or past resource tracking and show a significant increase in per capita domestic public expenditure over the last four years. In 15 low-income countries of sub-Saharan Africa, for example, average per capita domestic public expenditure on AIDS doubled from US$ 0.31 in 2001 to US$ 0.65 in 2005 (Figure 11.3). If South Africa, a middle-income country, is included in the calculation, the average per capita domestic public expenditure on AIDS for 2005 goes up to US$ 0.72.

THE COUNTRY RESPONSE INFORMATION SYSTEM
Historically, many factors have restricted a country’s capacity to use data for improving monitoring and evaluation.
These include limited human and financial resources, multiple reporting demands from stakeholders (including donors) and the lack of a national information system for data related to HIV. Programme managers find themselves having to report similar data in many different formats, while, at the same time, these data are seldom used at the national level as a basis for programme refinement and improvement. Even within and between national ministries, there is poor sharing and coordination of data.

A software program, the Country Response Information System, has been developed to address these problems. It provides the platform for a database to support monitoring and evaluation. More specifically, it provides countries with the ability to store and analyse indicator, project and research data and to exchange data with those from other systems.

The inability to easily and automatically exchange data between systems has been a long-standing barrier to gathering and analysing data from many different stakeholders and exchanging data among stakeholders. A working group, facilitated by the UNAIDS Secretariat, has overcome this barrier by developing a standard transmission format (XML schema) for monitoring and evaluation data. This format has now been integrated into the Country Response Information System and a number of other data management software programs including the World Health Organization’s HealthMapper, the United Nations Development Group’s DevInfo, the Food and Agriculture Organization of the United Nations’ KIDS, the United States Government’s Epi Info and the MACRO HIV Survey Indicators Database. Recently, a prototype based on the Country Response Information System has been developed for the United States President’s Emergency Plan for AIDS Relief.

More than 60% of the countries reporting progress in 2005 on the 2001 Declaration of Commitment are using the Country Response Information System, indicating that this system has been catalytic in supporting development of monitoring and evaluation systems in countries (Figure 11.4).

**INDIVIDUAL AND HOUSEHOLD INFORMATION**

Many of the monitoring and evaluation indicators developed for HIV and AIDS depend on gathering information from individuals or households. Ensuring that this information is useful has required considerable effort to ensure that standard definitions and sets of data are collected both from these and other sources, including clinics and hospitals. In 2004, for example, various international and national organizations agreed on a minimum set of data required for optimum patient management and monitoring and this data set is now being used for monitoring antiretroviral therapy at many different health facilities (WHO, 2004a, 2004b). Workshops have been held to develop guidelines and plan projects to develop tools for the electronic storage and transfer of data from individual patients (WHO, 2004c, 2004d).

**LACK OF EVALUATION**

Monitoring and evaluation activities to date have focused largely on developing indicators and establishing systems for monitoring. The Evaluation Working Group within the Monitoring and Evaluation Reference Group is now focused on improving evaluation, with the aim of producing new data about the
Botswana’s National AIDS Coordinating Committee developed its National Monitoring and Evaluation Plan 2003–2007. It has also established a related national monitoring and evaluation system called the Botswana HIV/AIDS Response Information Management System, based on the Country Response Information System. A technical working group has been set up to manage the system. As part of this process, the group developed a statement of user requirements and assessed various software options, including the Country Response Information System, to identify the program that most suited the needs of Botswana.

In one of the pilot projects, the Ministry of Local Government tested the Country Response Information System in two districts that had previously sent their raw data to the central office for analysis and report generation. The districts responded positively to the fact that the system enabled them to analyse and report their own data and maintain data integrity while allowing an easy exchange of data with the central office. The central office receiving the data responded positively to the fact that the system was compatible with other available software.

Surveillance, as carried out in the public health field, refers to the continuing and systematic collection, analysis, interpretation and dissemination of health information. It helps define the nature and extent of a health problem and the impact that programmes and services are having on the problem.

HIV surveillance based on case reports collects data from specific patients in clinical settings who have been tested for and been diagnosed with HIV. In contrast, sentinel serosurveillance uses blood samples collected for other purposes (e.g. testing in antenatal clinics to screen for certain diseases or monitor patient progress) and is typically anonymous and unlinked to specific individuals. Since HIV-positive people often have no symptoms of infection for many years after they are infected and case reporting typically captures only a small fraction of all people living with HIV in countries with weak health systems, sentinel serosurveillance is a necessary component of HIV surveillance to monitor the epidemic’s growth and keep track of who has become newly infected, how and where.
equipment), other biological markers (e.g. the presence of sexually transmitted infections) and knowledge or lack of knowledge about how HIV is transmitted. Second generation HIV surveillance expands the scope of surveillance systems to include these additional factors and also includes surveillance of related infections, mortality data and behavioural studies, such as the Demographic and Health Surveys, which provide data that can be used to track changes in sexual behaviour and condom use.

In many countries, HIV surveillance has focused on the general population. Often, blood donors and pregnant women are tested and when negligible levels of infection are found in those groups, it is assumed that infection levels are generally low or non-existent. Such surveillance can fail to detect a concentrated or emerging epidemic among subpopulations at higher risk of infection such as sex workers, injecting drug users, men who have sex with men and people with sexually transmitted infections.

The UNAIDS/WHO Guidelines for Second Generation HIV Surveillance recommend different sets of surveillance measures according to the type of epidemic, i.e. low level, concentrated and generalized (UNAIDS/WHO, 2000).

A 2004 study examined HIV sentinel serosurveillance in 132 countries from 1995 to 2002 and found high-quality surveillance in only 58% of countries with generalized epidemics, 34% of countries with concentrated epidemics and 10% of countries with low-level epidemics. Overall, the number of countries with high-quality surveillance had decreased from 43% in 1995 to 36% in 2002, although it had increased from 45% to 58% in countries with generalized epidemics (Garcia-Calleja et al., 2004).
concluded that many countries still have poor HIV sentinel serosurveillance systems. The study did not look at other components of second generation surveillance, but these are likely to be weaker than sentinel serosurveillance in most countries.

**Applying the “Three Ones” and the Global Task Team recommendations**

In March 2005, the Paris Declaration gave greater definition to the framework for international cooperation on country-led development. This was followed in June 2005 by the Global Task Team’s recommendations, which gave further definition to the framework for international cooperation on country-led responses to AIDS. This ‘new aid architecture’, as some call it, is helping countries marshal international support for their efforts to apply the “Three Ones” and build their capacity to respond to AIDS. The ultimate aim is to make the best possible use of the limited resources at their disposal and accelerate access to prevention, treatment, care and support.

In Nigeria, the National Action Committee on AIDS and the National Expanded Theme Group on HIV/AIDS moved quickly to mobilize key stakeholders in an exercise that looked at the implications of the Global Task Team’s recommendations. In November 2005, they presented their own recommendations in a report entitled *Domestication of the Global Task Team Recommendations in Nigeria* (National Expanded Theme Group on HIV/AIDS Nigeria, 2005). Many other countries have been engaged in similar exercises, identifying where they fall short of complying with the “Three Ones” and referring to the Global Task Team’s recommendations for guidance as they outline strategies for action.

In Kenya, the National AIDS Control Council and a broad range of partners were strongly committed to applying the “Three Ones” as they developed the Kenya National HIV/AIDS Strategic Plan for 2006–2010, translating it into a detailed workplan and budget for each of the years it covers. The resulting document is one of the most comprehensive national AIDS plans currently on record (Kenya National AIDS Control Council, 2005). Soon there will be more such plans in place and each will be a useful reference for other countries in the continuing process of reviewing and updating national plans and otherwise building countries’ capacity to respond to AIDS.