The global HIV challenge: assessing progress, identifying obstacles, renewing commitment

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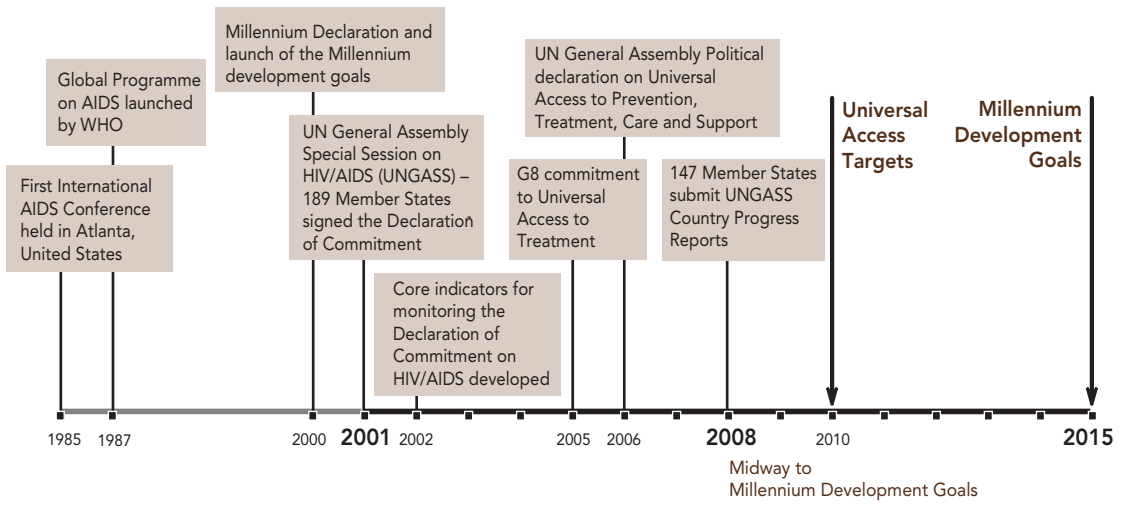
Chapter 1

FIGURE 1.1 Selected events in the global response to the epidemic



Key Findings

- This report provides the most comprehensive global assessment ever undertaken of the response to HIV, being based on reports from 147 countries on national progress in implementing the 2001 *Declaration of Commitment on HIV/AIDS*.
- Unprecedented numbers of civil society groups have joined their government counterparts and participated in this reporting process, using their participation as a means to communicate to the world on the situation within their country.
- The HIV response is critical to progress across the breadth of the global development agenda.
- A 6-fold increase in financing for HIV programmes in low- and middle-income countries is beginning to bear fruit, with many countries making major progress in lowering AIDS deaths and preventing new infections.
- Progress remains uneven, however, and the epidemic's future is still uncertain, underscoring the need for intensified action to move towards universal access to HIV prevention, treatment, care, and support.
- Achieving the many political commitments made on HIV will require stronger leadership, building on recent successes, taking account of lessons learnt, increased financial resources, improved coordination of effort, and effective action to address societal determinants of HIV risk and vulnerability.
- Monitoring and evaluation systems are being strengthened, largely with external funds, because countries are only beginning to avail themselves of the standard provision that up to 10% of programme funds can be directed to strengthening such systems.

The HIV epidemic has changed our world

In the countries most heavily affected, HIV has reduced life expectancy by more than 20 years, slowed economic growth, and deepened household poverty. In sub-Saharan Africa alone, the epidemic has orphaned[1] nearly 12 million children aged under 18 years. The natural age distribution in many national populations in sub-Saharan Africa has been dramatically skewed by HIV, with potentially perilous consequences for the transfer of knowledge and values from one generation to the next. In Asia, where infection rates are much lower than in Africa, HIV causes a greater loss of productivity than any other disease, and is likely to push an additional 6 million households into poverty by 2015 unless national responses are strengthened (Commission on AIDS in Asia, 2008). According to the United Nations Development Programme (UNDP), HIV has inflicted the "single greatest reversal in human development" in modern history (UNDP, 2005).

At the same time, the epidemic has heightened global consciousness of health disparities, and catalysed unprecedented action to confront some of the world's most serious development challenges. No disease in history has prompted a comparable mobilization of political, financial, and human resources, and no development challenge has led to such a strong level of leadership and ownership by the communities and countries most heavily affected. In large part due to the impact of HIV, people throughout the world have become less willing to tolerate inequities in global health and economic status that have long gone unaddressed.

In 2000, global leaders embraced a series of Millennium Development Goals that reflected newfound resolve to make the world safer, healthier, and more equitable. Millennium Development Goal 6 provides that, by 2015, the world will have halted and begun to reverse the global HIV epidemic. By making the HIV response one of the overriding international priorities for the 21st century, world leaders acknowledged the centrality of the HIV response to the future health and well-being of our increasingly interconnected planet.

At the first-ever Special Session on HIV/AIDS of the United Nations General Assembly (UNGASS) in 2001, UN Member States strengthened the response to Millennium Development Goal 6 by unanimously endorsing the *Declaration of Commitment on HIV/AIDS*. This *Declaration* included time-bound pledges to generate measurable action and concrete progress in the AIDS response. At the five-year review of implementation of the *Declaration of Commitment* in 2006, UN Member States reaffirmed the pledges made at the 2001 Special Session. Also, in the *Political Declaration on HIV/AIDS*, they committed to taking extraordinary action to move towards universal access to HIV prevention, treatment, care, and support by 2010.

This *Report on the global AIDS epidemic* emerges at the halfway mark between the 2001 UNGASS *Declaration of Commitment* and the 2015 target for Millennium Development Goal 6, and only two years before the agreed target date for universal access. This juncture provides an opportunity to assess the HIV response and to understand what must be done to ensure that nations are on course to achieve the HIV commitments they have made.

[1] Contrary to traditional usage, UNAIDS uses "orphan" to describe a child who has lost either one or both parents; the organization uses the terms "maternal orphan", "paternal orphan", and "double orphan" to describe a child who has lost its mother, father, or both parents, respectively.

An effective HIV response: vital to achievement of the Millennium Development Goals

Although one of the Millennium Development Goals (Goal 6) specifically addresses the HIV epidemic, an effective HIV response will also support achievement of other Millennium Development Goals embraced by the world community, as shown below.

Millennium Development Goal 1: *Eradicate extreme poverty and hunger.* Especially in high-prevalence settings, HIV deepens household poverty, slows economic growth, and undermines vital sectors on which economic development depends. In rural areas with high HIV prevalence, the epidemic degrades agricultural sectors and exacerbates food insecurity (see Chapter 6). Alleviating the epidemic's burden helps countries to grow their economies, reduce income inequalities, and prevent acute hunger.

Millennium Development Goal 2: *Achieve universal primary education.* The HIV response promotes universal education initiatives; these provide an essential venue for HIV prevention education for young people, and reduce girls' vulnerability to HIV (see Chapter 4). School attendance is a central focus of initiatives to address the needs of children orphaned or made vulnerable by HIV (see Chapter 6). Better access to treatment helps to minimize the epidemic's impact on fragile educational systems; it also reduces the likelihood that young people will be withdrawn from school in response to HIV in the household.

Millennium Development Goal 3: *Promote gender equality and empower women.* The HIV response is helping to drive efforts to reduce inequalities between the sexes (see Chapter 3). Countries are now monitored on the degree to which gender equity is a component of national HIV responses. Thus, the epidemic has increased the urgency of initiatives to forge new gender norms, and extensive worldwide efforts are under way to develop new HIV prevention methods that women may initiate (see Chapter 4). HIV has prompted parents, communities, and governments alike to approach the sexual and reproductive health needs of women, girls, and sexual minorities with renewed commitment.

Millennium Development Goal 4: *Reduce child mortality*. At the beginning of this decade, AIDS accounted for 3% of all deaths in children aged under 5 years—a toll that is likely to be much larger today in light of the high level of mother-to-child HIV transmission in the intervening years (WHO, 2005). A key component of a comprehensive HIV response is the scaling up of prevention strategies that can nearly eliminate the risk of mother-to-child HIV transmission (see Chapter 4).

Millennium Development Goal 5: *Improve maternal health*. Women now account for about half of all people living with HIV, and for more than 60% of infections in Africa (see Chapter 2). Greater access to antiretroviral medicines is improving the health and well-being of women, through programmes that couple prevention of mother-to-child transmission with continuing treatment to help mothers remain alive and in good health to care for their children. Integration of HIV initiatives with programmes addressing sexual and reproductive health is helping to ensure that women have access to the information and services they need to make informed reproductive decisions.

Millennium Development Goal 6: *Combat HIV/AIDS, malaria, and other diseases.* A strong HIV response yields health benefits that extend well beyond HIV itself. For example, HIV is an important contributing factor in the continued spread of tuberculosis. The push to expand access to HIV treatment in resource-limited settings is helping to strengthen fragile health infrastructures and is driving improvements in human capacity in low- and middle-income countries (see Chapter 5).

Millennium Development Goal 8: *Develop a global partnership for development.* Perhaps more than any other issue in our time, HIV has highlighted global and economic inequities, and has galvanized action on international development. HIV has helped place people at the centre of development; it has also helped to ensure that development strategies are inclusive, respectful of human rights, and country owned.

Promising progress, but enduring challenges

The 6-fold increase in financing for HIV activities in low- and middle-income countries during this decade is beginning to yield results. For the first time since what we now know as AIDS was recognized 27 years ago, signs of major progress in the HIV response have become apparent. The annual number of AIDS deaths has declined in the past two years from 2.2 million [1.9 million–2.6 million] in 2005 to 2.0 million [1.8 million–2.3 million] in 2007, in part as a result of the substantial increase in access to HIV treatment in recent years. In a number of heavily affected countries—such as Kenya, Rwanda, Uganda, and Zimbabwe—dramatic changes in sexual behaviour have been accompanied by declines in the number of new HIV infections, contributing to a global stabilization, beginning in the late 1990s, in the percentage of people aged 15–49 who are infected with HIV.

But these gains have not been consistent within and between regions, and favourable epidemiological and behavioural trends have not been sustained in some countries (see Chapter 4). Infections are on the rise in a number of countries including China, Germany, Indonesia, Mozambique, Papua New Guinea, the Russian Federation, Ukraine, the United Kingdom, and Viet Nam. In other countries—such as Lesotho, Namibia, South Africa and Swaziland—HIV prevalence appears to have stabilized at extraordinarily high levels. Although the number of people on antiretroviral drugs in low- and middle-income countries has risen, most of those who need such therapies are not currently receiving them (see Chapter 5). Moreover, the epidemic is outpacing the rate at which these drugs are being delivered. In 2007, the estimated number of new HIV infections was 2.5 times higher than the increase in the number of people on antiretroviral drugs in that year, underscoring the need for substantially greater success in preventing new HIV infections.

The recent stabilization of the global epidemic cannot obscure its most important aspect—its profound human toll. Since the beginning of the epidemic, 25 million people have died of HIV-related causes. Collectively, these deaths represent an incalculable loss of human potential. Individually, each is associated with enduring trauma in households and communities.

There is also a risk that the important progress achieved in recent years might lull some into complacency. Indications that the annual global number of new HIV infections may have peaked

around the beginning of the century have generated speculation in the popular media that the epidemic may have entered a long-term decline (McNeil, 2007). Yet the history of infectious disease suggests that epidemics are often cyclical, characterized by waves of infection that make it difficult to predict the epidemic's future course (Commission on AIDS in Asia, 2008; May & Anderson, 1979). Indeed, the HIV epidemic has repeatedly defied predictions derived from epidemiological modelling. A decade ago, few would have predicted that one million or more people would be living with HIV in the Russian Federation alone. If the epidemic's history is any indication, HIV is likely to have additional surprises in store that the world must be prepared to address.

Above all, the dimensions of the epidemic remain staggering. In 2007 alone, 33 million [30 million–36 million] people were living with HIV, 2.7 million [2.2 million–3.2 million] people became infected with the virus, and 2 million [1.8 million–2.3 million] people died of HIV-related causes.

Purpose and contents of the report

This report examines the current status of the global HIV response in a series of chapters devoted to key thematic areas. For each of these themes, the report assesses the response by seeking to answer a series of related questions:

- Are the right actions being taken?
- Are the right actions being undertaken in the right manner?
- Have these actions been sufficiently scaled up to make a difference?

To answer these questions, the report relies heavily on data reported to UNAIDS by 147 UN Member States in early 2008; the data relate to 25 core UNGASS indicators (Table 1) developed to measure progress in implementing the *Declaration of Commitment*.[2] The number of countries reporting on these indicators, and the completeness of national reports, have steadily improved since reporting began in 2003 (Figure 1.2). This improvement underscores increased national commitment to HIV monitoring and evaluation; it also shows

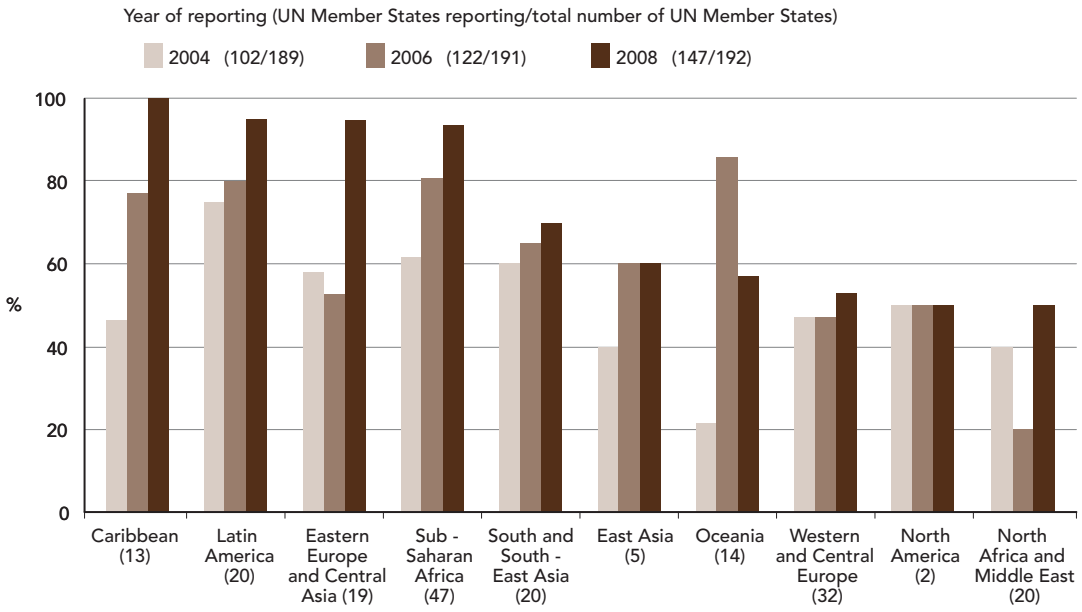
[2] Copies of the reports submitted by countries are available on the UNAIDS web site (http://www.unaids.org/en/KnowledgeCentre/HIVData/CountryProgress/2007CountryProgressAllCountries.asp).

TABLE 1 National indicators for the implementation of the *Declaration of Commitment on HIV/AIDS*

National Commitment and Action
1. Domestic and international AIDS spending by categories and financing sources
2. National Composite Policy Index (Areas covered: gender, workplace programmes, stigma and discrimination, prevention, care and support, human rights, civil society involvement, and monitoring and evaluation)
National Programmes (blood safety, antiretroviral therapy coverage, prevention of mother-to-child transmission, co-management of Tuberculosis and HIV treatment, HIV testing, prevention programmes, services for orphans and vulnerable children, and education)
3. Percentage of donated blood units screened for HIV in a quality assured manner
4. Percentage of adults and children with advanced HIV infection receiving antiretroviral therapy
5. Percentage of HIV-positive pregnant women who received antiretrovirals to reduce the risk of mother-to-child transmission
6. Percentage of estimated HIV-positive incident Tuberculosis cases that received treatment for Tuberculosis and HIV
7. Percentage of women and men aged 15-49 who received an HIV test in the last 12 months and who know their results
8. Percentage of most-at-risk populations that have received an HIV test in the last 12 months and who know their results
9. Percentage of most-at-risk populations reached with HIV prevention programmes
10. Percentage of orphaned and vulnerable children aged 0–17 whose households received free basic external support in caring for the child
11. Percentage of schools that provided life skills-based HIV education in the last academic year
Knowledge and Behaviour
12. Current school attendance among orphans and among non-orphans aged 10–14*
13. Percentage of young women and men aged 15–24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission*
14. Percentage of most-at-risk populations who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission
15. Percentage of young women and men aged 15–24 who have had sexual intercourse before the age of 15
16. Percentage of women and men aged 15–49 who have had sexual intercourse with more than one partner in the last 12 months
17. Percentage of women and men aged 15–49 who had more than one sexual partner in the past 12 months reporting the use of a condom during their last sexual intercourse*
18. Percentage of female and male sex workers reporting the use of a condom with their most recent client
19. Percentage of men reporting the use of a condom the last time they had anal sex with a male partner
20. Percentage of injecting drug users reporting the use of a condom the last time they had sexual intercourse
21. Percentage of injecting drug users reporting the use of sterile injecting equipment the last time they injected
Impact
22. Percentage of young women and men aged 15–24 who are HIV infected*
23. Percentage of most-at-risk populations who are HIV infected
24. Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy
25. Percentage of infants born to HIV-infected mothers who are infected

* Millennium Development Goals indicator

FIGURE 1.2 Percentage of UN Member States reporting by region, 2004–2008



Source: UNGASS Country Progress Reports 2008.

increased global ownership of the tracking of HIV commitments made by countries earlier this decade. In 2008, all Caribbean countries reported on core indicators; reports were also received from nearly all countries in Latin America, Eastern Europe and Central Asia, and sub-Saharan Africa. Reporting rates were notably lower in other regions.

Based on the specific time-bound pledges made by countries at the 2001 Special Session of the UN General Assembly on HIV/AIDS, the core UNGASS indicators cover a broad array of variables, such as HIV prevalence among young people aged 15–24, coverage of antiretroviral therapy and key HIV prevention initiatives, services to support children orphaned or made vulnerable by HIV, and national adoption of recommended HIV policies. Information from national progress reports is supplemented by other data sources such as household surveys, civil society reports, and the budgets and programme-monitoring data of donor governments, UNAIDS Cosponsors, philanthropic foundations, and biomedical research agencies.

Civil society engagement in monitoring progress in the HIV response

The participation of civil society is an essential part of the reporting process. UNAIDS engaged a consortium of civil society organizations, led by the International Council of AIDS Service Organizations and the International Women's Health Coalition, to support civil society organizations in national reporting.[3]

[3] For a full description of the methods used for national reporting of progress in implementing the *Declaration of Commitment*, including the extent of civil society involvement in national reporting, see Annex 2.

Important progress has been made since the last reporting round regarding inclusion of civil society in national reporting. National HIV authorities, which were responsible for submitting data on core indicators for the *Declaration of Commitment*, indicated that civil society provided input in 82% of countries, and people living with HIV provided input in 75%. In Indonesia, for example, civil society agreed to include a "community report" representing civil society's perspectives in the official submission to UNAIDS.

Civil society has an important, formal role in the completion of the National Composite Policy Index (NCPI). This index assesses progress in development and implementation of sound national HIV policies and strategies. It is an extensive questionnaire completed through a review of relevant documents and through interviews with people most knowledgeable about the topics covered. Part A of the NCPI is completed by government officials, whereas Part B is completed by representatives from civil society and by bilateral and multilateral organizations.

In all countries, civil society participated in the completion of the nongovernmental component of the NCPI.[4] Altogether, more than 700 local nongovernmental organizations (represented by many more individuals) served as key informants on the NCPI, far outnumbering the international nongovernmental and bilateral and multilateral organizations involved. UN agencies participated in completion of the nongovernmental part of the NCPI in 65% of countries, and bilateral donor agencies assisted in 29% of countries.

Civil society groups in 19 countries submitted additional parallel information on the national HIV response. This information included complementary or qualitative data to supplement national reports, such as survey data on sexual and reproductive health and rights (Gestos, 2008). In some of these countries, where civil society was not included in national reporting or where countries failed to submit a national report, "shadow" reports were submitted.

Using evidence to assess progress

Altogether, the body of data assembled in 2008 on national efforts permits the most comprehensive evaluation ever undertaken of global, regional, and national progress in addressing the epidemic. The information presented in this report enables the reader to assess progress made since 2001, identify the strengths and weaknesses of the response to date, and better understand the magnitude of the challenges facing the world in its quest to begin to reverse the epidemic by 2015. A closing chapter on scaling-up (see Chapter 7) specifically examines the main obstacles to accelerated success on HIV and describes the most promising strategies for overcoming these obstacles.

The report also includes profiles of individuals from different regions who are living with, affected by, or responding to, HIV. These profiles are a reminder of the human dimensions of the global HIV response—that attached to each number cited in this report is a person who possesses an inalienable human right to dignity, respect, and effective health care. They also underscore one of the enduring lessons of HIV—that international health and development efforts must ultimately be owned and led by the people who are most affected.

[4] Not all Member States submitted NCPI data (130/192), and four countries did not indicate who provided the NCPI responses.

Improved country-level monitoring and evaluation: facilitating an evidence-informed response to the epidemic

Since HIV was first recognized, approaches and methodologies to monitor the epidemic and the response have continuously improved. As a result, the world is better equipped than ever to estimate HIV prevalence or the rate of new HIV infections, to determine the extent of programme coverage, to characterize and evaluate national responses, and to gauge the level of funding available for HIV programmes in low- and middle-income countries.

Country reports on progress

By the time this report went to press, 147 UN Member States had reported national information against the 25 core UNGASS indicators developed by UNAIDS and its partners to track implementation of the *Declaration of Commitment on HIV/AIDS*. As country progress reports were submitted early in 2008, UNAIDS made them available in unedited form on the Internet.

For the first time, this report permits an understanding of the main trends in the HIV response for key indicators that have not changed significantly. For example, the report examines trends in HIV prevalence and knowledge among young people, access to antiretroviral therapy, and national adoption of relevant human rights protections. It also highlights regional and subregional variations in epidemiological trends, behaviours, and national responses, in recognition of the limited usefulness to national decision-makers of global numerical values on HIV indicators.

This report provides an initial assessment of the latest information on the epidemic and on national responses. UNAIDS and its research partners plan to follow up the indicator data summarized in this global report with more in-depth analytical papers in particular thematic areas and with studies that more exhaustively examine data pertinent to various regions.

Increasing national capacity on monitoring and evaluation

This report reflects some of the improvements that have occurred in national and global information systems in recent years. Beginning in 2004, UNAIDS embarked on a long-term effort to strengthen national systems for HIV monitoring and evaluation. By 2008, almost 60 monitoring and evaluation advisers had been placed in national and regional UNAIDS offices. These advisers:

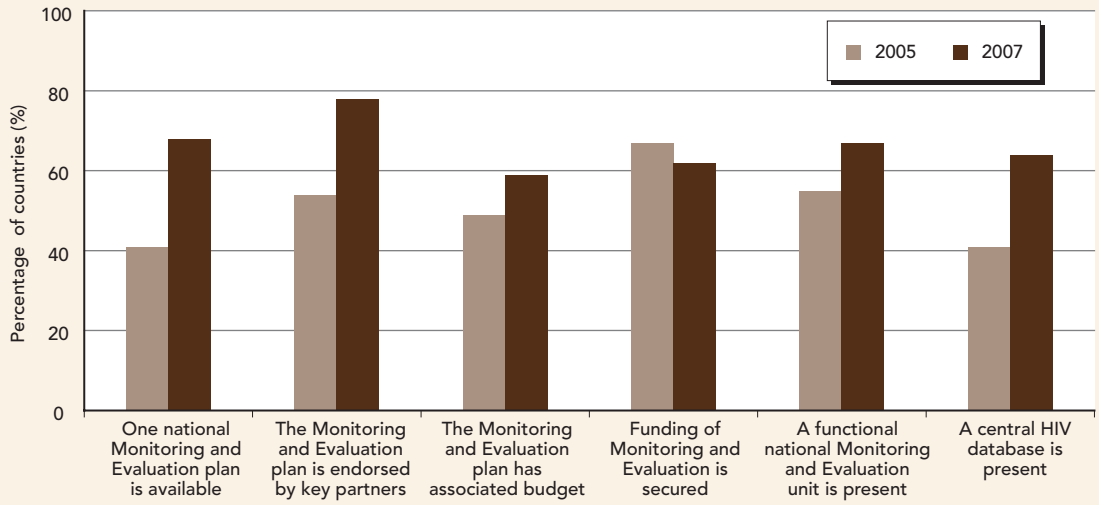
- provide continuing technical support for the building of national monitoring and evaluation capacity;
- work with national AIDS programmes to develop and monitor measurable indicators to assess implementation of national strategies; and
- help countries to extend monitoring and evaluation activities from the national to the district level.

Countries receive continuing support in the development and maintenance of a comprehensive national HIV monitoring and evaluation system. They also benefit from a growing array of other sources of technical assistance, including the Global AIDS Monitoring and Evaluation Team housed at the World Bank, and the United States President's Emergency Plan for AIDS Relief (PEPFAR). Individual UNAIDS cosponsors, such as the United Nations Children's Fund (UNICEF) (UNICEF, UNAIDS & WHO, 2008) and the World Health Organization (WHO), have also intensified their technical assistance on monitoring and evaluation.

The increased assistance to countries is intended to facilitate improved coordination of national stakeholders under a single monitoring and evaluation framework. This is in line with the "Three Ones" principles for effective country-level action—one national strategic framework, one national coordinating body, and one monitoring and evaluation system (see Chapter 7).

As indicated in Figure 1.3, the percentage of countries with a central HIV database increased from 41% in 2005 to 68% in 2007, and endorsement of the monitoring and evaluation plan by key partners also increased from 54% in 2005 to 78% in 2007 (UNGASS Country Progress Reports, 2008).

FIGURE 1.3 Percentage of countries with monitoring and evaluation components in place, 2005 and 2007



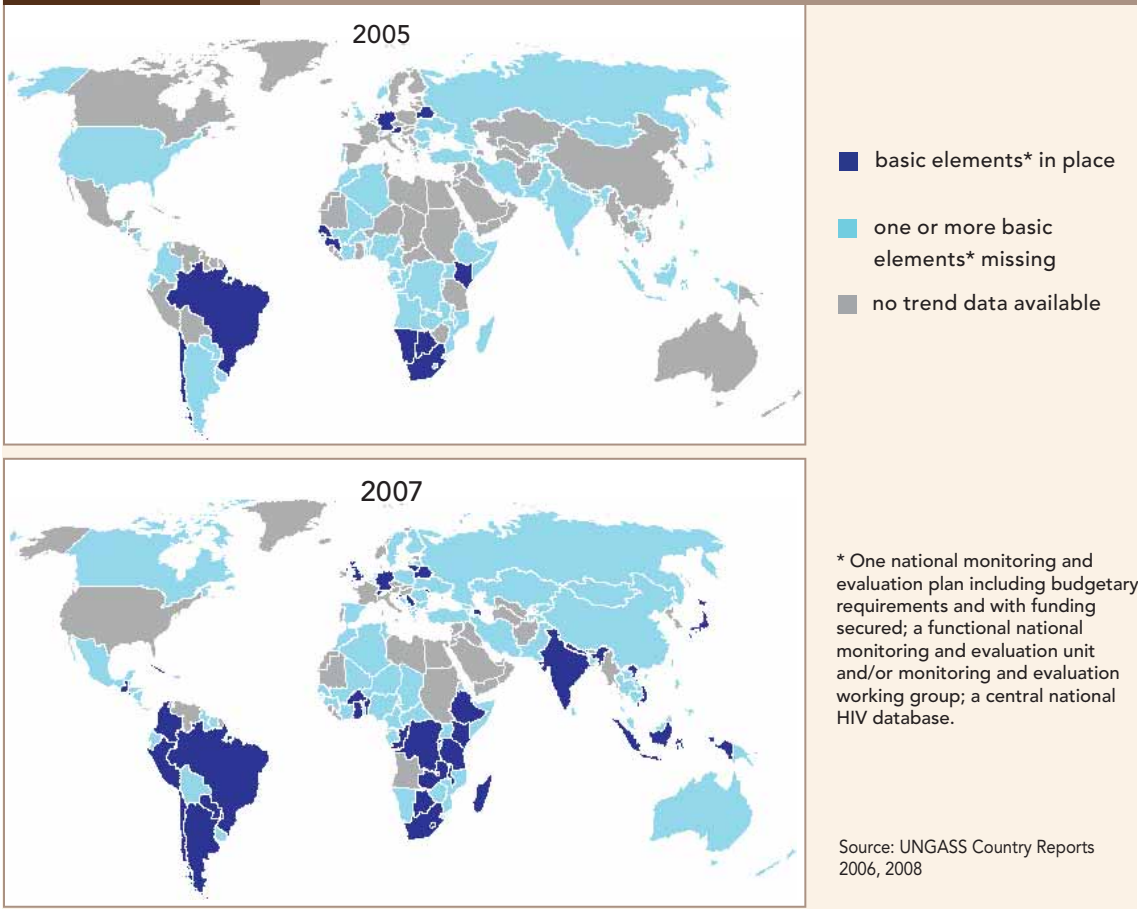
Source: UNGASS Country Progress Reports 2008.

Between 2005 and 2007, the number of countries having one costed national monitoring and evaluation plan with secured funding, as well as a functional national monitoring and evaluation unit or national technical working group, and a centralized HIV database, increased from 14 to 44 (UNGASS Country Progress Reports, 2008).

The Global Fund to Fight AIDS, Tuberculosis and Malaria has played a key role in driving improvements in national monitoring and evaluation systems. Proposals for assistance from the Global Fund must be based on sound country-level information. In addition, timely and accurate national progress reporting is essential for securing continued funding under the performance-based approach of the Global Fund.

Not only are systems for monitoring and evaluation stronger, but available methods to track key aspects of the epidemic have improved. In countries with generalized epidemics, increased use of national household surveys has increased the accuracy and reliability of national estimates of HIV prevalence, incidence, and mortality (see Chapter 2). Figure 1.4 shows global trends in strengthening of monitoring and evaluation systems.

FIGURE 1.4 Global trends in monitoring and evaluation system strengthening, 2005 and 2007



* One national monitoring and evaluation plan including budgetary requirements and with funding secured; a functional national monitoring and evaluation unit and/or monitoring and evaluation working group; a central national HIV database.

Source: UNGASS Country Reports 2006, 2008

Moving towards universal access to HIV prevention, treatment, care, and support

To quicken progress towards the 2015 deadline for the Millennium Development Goals, the global community has embraced the goal of moving towards universal access to HIV prevention, treatment, care, and support by 2010. This step is of historic significance in global health and development. Converting aspirations into achievements will require unprecedented commitment and resources, as well as innovative ways of approaching challenges and bottlenecks

Key weaknesses and gaps in monitoring and evaluation

Although improvements in national monitoring and evaluation capacity are evident, critical gaps and weaknesses remain. One in four countries with a national monitoring and evaluation plan have not calculated the budgetary requirements, and one in three have not secured funding to implement the plan. More than one third of countries with a monitoring and evaluation plan have no centralized HIV database. To build the national capacity needed to provide a robust information base for decision-making on policies and programmes, countries require ready access to financial and technical resources for monitoring and evaluation, including HIV surveillance. Although the Global Fund, the World Bank, and PEPFAR permit as much as 10% of any grant to be earmarked for monitoring and evaluation, countries are just beginning to avail themselves of this provision.

Reported expenditures[5] on monitoring and evaluation range from 0.1% of national HIV expenditures to 15.6% (median 0.9%, UNGASS indicator 1, 2006-2007 data). In more than half of countries (54%), monitoring and evaluation activities are exclusively financed through external sources. Only one in 10 countries report financing of HIV monitoring and evaluation exclusively through domestic funding. The imbalance in financing for monitoring and evaluation raises concerns about the sustainability of this essential function in future years. In addition, external funding for monitoring and evaluation is not necessarily supporting the national monitoring and evaluation system. For example, Guyana indicates considerable progress in monitoring and evaluation, but several donor-funded projects with monitoring and evaluation components are not linked to the national monitoring and evaluation plan (Guyana UNGASS Country Progress Report 2008).

As national monitoring and evaluation capacity continues to grow, countries and national partners must ensure that they actually use the information generated to improve decision-making. Evaluation of resource flows has found that national allocation of prevention resources is sometimes sharply at odds with the picture of the epidemic generated by national surveillance systems (UNAIDS, 2004). Similarly, inertia and bureaucratic pressures sometimes work against the discontinuation or revision of particular programmes or strategies, even when evaluation data indicate that these approaches are ineffective.

[5] A total of 48 countries reported expenditures for 2006 or 2007 on monitoring and evaluation.

What is universal access?

Universal access signifies both a concrete commitment and a renewed resolve among people the world over to reverse the course of the epidemic. It is a process that builds on past initiatives and infuses existing efforts with greater momentum.

Universal access does not imply that there will be, or should be, 100% coverage of HIV prevention, treatment, care, and support services—even in high-income countries where health care is universally available, some patients who are medically eligible for antiretroviral drugs are not receiving them for various reasons (e.g. a deliberate decision not to undergo testing or a decision to initiate therapy at a later time). Rather, by moving towards nationally set targets for universal access, the world has committed to make concrete, sustained advances towards a high level of coverage for the most effective programmes needed to manage diverse epidemics in all regions. The basic principles for scaling up towards universal access emphasize that services must be equitable, accessible, affordable, comprehensive, and sustainable over the long-term.

Because different settings often have distinctly different needs, universal access cannot fit a standardized time frame or approach, and countries will adopt varying time lines and strategies to achieve scale-up. For example, countries with generalized epidemics (see Chapter 4) require very high coverage for initiatives aimed at the general popuation (e.g. mass media awareness campaigns, school-based education, and workplace prevention programmes). In contrast, countries with low-level and concentrated epidemics may require less intense coverage for initiatives aimed at the general population, but high coverage for programmes addressing populations most at risk of HIV exposure. By setting national targets, countries are holding themselves accountable to reach universal access within a time frame that is both urgent—galvanizing support and momentum around this goal—and feasible, and that will set them on the way to reach the 2015 Millennium Development Goals.

that have long impeded swifter progress on human development in resource-limited settings.

In 2005-2006, 123 countries and 7 regions, with assistance from UNAIDS, implemented consultative processes to determine the challenges associated with moving towards universal access to HIV prevention, treatment, care, and support. Results of these consultations informed deliberations at the High Level Meeting on HIV/AIDS at the UN General Assembly in June 2006.

This meeting resulted in a formal, unanimous endorsement by UN Member States of the goal of moving towards universal access by 2010 (UN General Assembly, 2006).

With normative guidance from UNAIDS (UNAIDS, 2006), countries in all regions initiated evidence-informed processes for achieving a national, multisectoral consensus on targets for universal access. As of March 2008, 105 countries had established targets for universal access to

HIV prevention, treatment, care, and support—including 76 countries that had incorporated these targets into their national strategic AIDS plans or broader development instruments (e.g. Poverty Reduction Strategy Papers, Medium Term Expenditure Frameworks). A total of 41 countries have defined the actions and costs required to achieve universal access—a key step in mobilizing the necessary resources to meet defined goals. Some countries have established especially ambitious targets, sometimes exceeding feasibility estimates for HIV treatment or other initiatives.

Following up on the target-setting processes, countries are now supporting universal access initiatives at subnational levels. In Nigeria, for example, strategic plans for universal access are being elaborated in six states.

Civil society advocacy for universal access

The movement towards universal access to HIV prevention, treatment, care, and support is serving as an effective vehicle for mobilizing civil society.

At country level, civil society has participated in the establishment of national targets for universal access, and is monitoring implementation of national plans to ensure greater accountability in the national response. In Malawi and Cambodia, for example, concerted advocacy by civil society organizations helped spur national decision-makers to establish ambitious targets for universal access. Similarly, in Nigeria, eight civil society networks have joined together to forge a civil society action plan on universal access—the "People's AIDS agenda"—released on World AIDS Day 2007.

Globally, the World AIDS Campaign is using the cause of universal access to mobilize diverse constituencies and civil campaigners. In July 2007, civil society campaigners from 35 regions convened under the World AIDS Campaign umbrella in Nairobi to share perspectives and coordinate efforts on promoting universal access. National AIDS campaigns are now active in five of the eight countries that comprise the Group of Eight (G8) leading industrialized nations, and these national campaigns are coordinating advocacy to ensure that HIV remains a priority for the G8.

The Coalition of Asia Pacific Regional Networks on HIV/AIDS developed a toolkit on 'Minimum Standards for Civil Society Participation in Universal Access Initiatives', drawing on regional and national consultations of civil society organizations. The toolkit is designed to be used by civil society representatives and other stakeholders to assess and promote greater civil society involvement in national universal access initiatives. In keeping with the principles outlined in the toolkit, UNAIDS sponsored a civil society consultation to inform the development of technical recommendations for scaling up HIV testing and counselling in the Asia and Pacific region. Regional forums for populations most at risk have also been convened to ensure strong civil society involvement in efforts to plan and implement scaled-up prevention programmes.

Activism to achieve results

Alessandra Nilo is co-founder and co-coordinator of GESTOS, a nongovernmental organization based in Brazil

For Alessandra Nilo, a Brazilian-based activist, her work on HIV is part of a broader struggle for social justice and human rights. "Over time it has become clearer that the issues of poverty, gender inequality, but above all, the cultural differences and challenges are all points which need to be addressed and dealt with once and for all", she says.

Alessandra and others joined together in 1993 to establish GESTOS, with the aim of providing psychosocial support and leadership training for people living with HIV in the Brazilian city of Recife. In subsequent years, GESTOS has become increasingly engaged in public policy analysis and advocacy, including monitoring the Brazilian government's progress in meeting its HIV commitments. In the second half of the 1990s, GESTOS began developing links with other groups in Latin America. In collaboration with other civil society groups, GESTOS was an active participant in the 2001 UN General Assembly Special Session on HIV/AIDS. Today, GESTOS works in 16 different countries and in 2008 reported on the status of sexual and reproductive health in these countries as a complement to national reporting on core indicators for the *Declaration of Commitment*.

Notwithstanding the epidemic's complexity, Alessandra says one of the most satisfying aspects of HIV activism is that solutions actually exist for many of the most important challenges. "What drives me to pursue my work as an activist is the possibility to find solutions and to deal with inequalities that are configured in a macrostructure of society in a somewhat more tangible manner. Here, in my community, I have taken action to ensure that those who were very poor before and who had never had the possibility of gaining access to adequate treatment for HIV/AIDS now have a chance to benefit from it, as well as gaining access to food aid, decent living conditions, and, above all, that the community may learn how to live with this epidemic."

Alessandra believes now is the time for the HIV response to show results. "Since 2001, there have been considerable investments concerning HIV/AIDS", she says. "What we need to do now is to show how this money is invested, show the results of this large number of investments and show clearly that it is necessary to make even more investments… In my opinion, we won't get there unless civil society is committed and involved."

For Alessandra, HIV activism is more than a cause, it is a way of life. "This is not a kind of work where one can just drop the pen and go home… We are people who are fighting for a cause, a social-welfare cause which mobilizes us 24 hours a day, seven days a week!"

Beginning to reverse the epidemic by 2015

A principal finding of this report is that, although some countries are on course to meet the 2010 targets in the *Declaration of Commitment*, others are not. Without a substantial strengthening and acceleration of the HIV response, many countries will not achieve universal access to HIV prevention, treatment, care, and support by 2010 or begin to reverse the epidemic by 2015. The global community should renew and strengthen its commitment to work with countries to expedite progress towards universal access to HIV prevention, treatment, care, and support.

Throughout the subsequent chapters, this report emphasizes a number of key factors that will affect the world's ability to meet the challenges ahead.

- *Building on success*. There has been recent progress across many regions in bringing essential HIV services to scale—reducing HIV incidence, stabilizing mortality rates, and in caring for children made vulnerable by the epidemic; this progress demonstrates that dramatic results are achievable, even in the most resource-limited settings.
- *Making the money work*. Despite the concrete progress achieved in recent years in gaining dramatically greater resources for HIV, countries are often struggling to translate new funding into scaled-up national programmes for HIV prevention, treatment, care, and support. The actions of diverse national stakeholders are often poorly coordinated, and infrastructure weaknesses are slowing the capacity of countries to absorb new financing. Important steps have been taken in recent years to address the factors that blunt the impact of increased funding; however, substantially stronger action is urgently needed to close the access gap for essential HIV programmes.
- *Tailoring the response to national and local needs*. What is referred to as the "global epidemic" is actually an amalgam of an almost infinite number of individual epidemics—in communities, districts, countries, subregions, and regions. No single pattern is sufficient for an effective response. Different countries may learn from one another in crafting, implementing, and revising their national strategies. However, national efforts need to be informed by evidence and carefully tailored to national needs and circumstances if they are to be optimally effective. National decision-makers and partners must "know their epidemic and their response" in order to develop national plans that will achieve maximum impact.
- *Addressing societal factors that increase HIV risk and vulnerability*, and deepen the epidemic's impact. Scale-up of programmes must be coupled with an intensified effort to address cross-cutting issues that impede an effective response. This is especially important in hyperendemic settings where marginal changes in risk behaviour are likely to have only limited impact on the epidemic's trajectory. All stakeholders should work to promote gender equality and women's empowerment, reduce HIV stigma and discrimination, and alleviate the social marginalization of groups at highest risk of exposure to HIV. Throughout this report, gender, social marginalization, and income inequality will be addressed as cross-cutting issues that play critical roles across the entire breadth of the HIV response.
- *Planning for the long-term*. Even were the world to begin to halt the epidemic by 2015, as envisioned in the Millennium Development Goals, the epidemic would remain an overriding global challenge for decades to come. While responding on an emergency basis with efforts to bring essential HIV prevention, treatment, care, and support to scale, an effective response needs to be sustained for the long-term. This will require novel mechanisms and the creation of capacity that does not currently exist; it will also require thoughtful planning, because some of the challenges

the epidemic will pose 10 or 20 years from now are likely to be quite different from those faced today.

- *Placing people at the centre of health and development*. One of the great lessons of the HIV epidemic is the central role of civil society—especially of people living with HIV and those most at risk of HIV exposure—in effective national and local responses. Yet the people most heavily affected by the epidemic continue to remain on the periphery of decision-making in many countries. To overcome the daunting obstacles hindering efforts to move towards universal access, countries urgently need the knowledge, passion, and commitment of those who possess the best insight on how to reach those in greatest need of HIV services.