

AIDS plus MDGs: synergies that serve people



“Halting and reversing the spread of AIDS is not only a goal within itself; It is a prerequisite for reaching almost all the others”

Ban Ki-moon, UN Secretary-General, 2008¹

The Millennium Development Goals (MDGs) reflect the global resolve to achieve unprecedented, radical progress across a broad range of health and international development priorities.

The MDGs were endorsed by the global community at the turn of the century. Since then, substantial gains have been made towards many of them.² Progress has been uneven, however, with major achievements in some countries and regions offset by inadequate progress elsewhere, and with significant inequalities within countries as to who benefits. The global development and economic context in which these goals were agreed has also shifted considerably, creating new challenges and opportunities—and calls for new solutions—in the campaign to achieve the MDGs.

We cannot continue to approach our work in the same way if we hope to achieve different results.

AIDS plus MDGs refers to an approach that recognizes and maximizes the AIDS response as essential to achieving the MDGs, and conversely, supports the role of the MDGs in achieving universal access to HIV prevention, treatment, care and support.

By situating the AIDS response within the broader development agenda and integrating AIDS with other health, development and human rights efforts, the world will accelerate progress across the array of MDGs, optimize efficiency in the use of resources and save and improve more lives. Investing strategically to address multiple MDGs, and releasing the power, capacity and innovation of the AIDS movement, may provide one of the best opportunities to “do the MDGs” differently.

AIDS IN CONTEXT

Despite progress, the epidemic rages on.

MDG 6 calls for concerted action to combat HIV/AIDS, malaria and other diseases. At the heart of this goal is assuring universal access to HIV prevention, treatment, care and support.

On the eve of the MDG summit, the AIDS movement can reflect on remarkable progress in recent years—more than 5 million people in low- and middle-income countries are now receiving antiretroviral treatment, living longer, healthier lives with lowered viral loads. Rates of infection dropped 17 percent worldwide between 2001 and 2008. HIV transmission from mother to child can be prevented in almost every case with a simple, inexpensive intervention. And at the 2010 International AIDS Conference, researchers announced a breakthrough development on a microbicide gel women could use to prevent sexual transmission of HIV. People living with HIV and civil society groups have also opened up spaces to discuss sensitive issues—such as gender relations, sexual orientation and health as a human right—that have had a profound effect beyond the AIDS response.

But on this day, worldwide, 7,400 people will be infected with HIV—a rate that significantly outpaces treatment uptake. For every two people who are able to start treatment, another five people are newly infected.³

And although the AIDS epidemic is most acutely felt in sub-Saharan Africa, AIDS is now, according to UN Secretary-General Ban Ki-moon, “Asia’s most deadly infectious disease.”⁴

The AIDS epidemic is at a tipping point. New approaches, innovative partnerships and renewed momentum are needed to stay on the right side of the divide and to ultimately achieve UNAIDS’ vision of reaching **zero new HIV infections, zero discrimination and zero AIDS-related deaths** worldwide.

Development priorities are changing.

For decades, HIV has been addressed as global public health crisis requiring an emergency response. This approach has been a powerful motivator for mobilising resources and expanding HIV programmes, and it remains relevant in many contexts. Donor priorities, however, appear to be shifting, often away from MDG 6 and towards other health-related MDGs and development challenges. Donor allocations are increasingly subsumed in sector-wide funding, used for health systems strengthening or are being allocated to those MDGs considered to be veering the farthest off track, like maternal and child health.

The gap is widening between resources available and resources needed.

The global economic downturn has led many countries to critically reconsider aid commitments and to look for better evidence of results. In 2009, the push to mobilise increased financial resources for AIDS seemed to stall. In 2010, an estimated \$26.8 billion dollars is required to meet country-set targets for universal access to HIV prevention, treatment, care and support, but only \$15.9 billion is available.⁵ The gap continues to widen, as it does for other health, development and human rights priorities.

AIDS plus MDGs is an opportunity to respond in a fresh way to the changing context and to accelerate progress in achieving the MDGs.

Putting this approach in place will require new ways of thinking and operating—in the AIDS field and across the development spectrum. High-level political support will be essential. So will a commitment to further build the evidence base that drives every action—identifying optimally effective approaches, developing good practices and promoting accountability.

The UNAIDS family, inspired by the potential to inaugurate a more efficient and effective approach to AIDS and other development challenges, is taking concrete steps to realize this agenda with the meaningful involvement of our new and existing partners. With the 2015 deadline for achievement of the MDGs approaching, UNAIDS has made the *AIDS plus MDGs* agenda a unifying principle for its work.

The PLUS of AIDS plus MDGs

1. AIDS plus MDGs *builds bridges for health, development and human rights*

Since its earliest days, AIDS was understood as a disease that was propelled by social drivers such as gender inequality, human rights violations, poverty, mis-information and stigma and discrimination. With the advent of interventions like testing and treatment, the focus shifted towards a more medicalized approach to the epidemic. But today, the same social drivers persist, fuelling people's vulnerability to HIV and exacerbating its impact across an array of health, development and human rights concerns.

To be effective and sustainable, the AIDS response, working strategically with other development partners, must continue and ramp up its push for positive social change and become more holistic in approaching these drivers and the companion health, development and rights challenges that affect and are affected by the epidemic—like maternal and child health, gender violence and inequality, universal education and infectious diseases like tuberculosis. AIDS responses must reach beyond the artificial boundaries of a single disease.


In six hyper-endemic countries, AIDS is responsible for over 40% of **child mortality**.⁶ According to one global analysis, every additional percentage point of HIV prevalence is associated with 8% higher infant mortality and 9% higher under-5 mortality.⁷ Conversely, a sound AIDS response saves infants' and children's lives. For example, after access to maternal antiretroviral therapy (ART) was improved in KwaZulu Natal, South Africa, child mortality declined by 34%.⁸


The impact of HIV on **maternal mortality** is also striking. Evidence shows that in the absence of HIV, the estimated number of maternal deaths worldwide would have been 18% lower in 2008.⁹

New studies from South Africa show that ART roll-out is associated with significant declines in new cases of **tuberculosis**, demonstrating that scaling up HIV treatment has the potential to reduce tuberculosis in countries with high HIV prevalence.¹⁰

The AIDS response has important implications for education goals as well. In Malawi, the scale-up of ART between 2002 and 2006 provided life-prolonging treatment to more than 2,000 teachers.¹¹

The 8 Millennium Development Goals

 **Goal 1: Eradicate extreme poverty and hunger**

 **Goal 2: Achieve universal primary education**

 **Goal 3: Promote gender equality and empower women**

 **Goal 4: Reduce child mortality**

 **Goal 5: Improve maternal health**

 **Goal 6: Combat HIV/AIDS, malaria and other diseases**

 **Goal 7: Ensure environmental sustainability**

 **Goal 8: Develop a Global Partnership for Development**

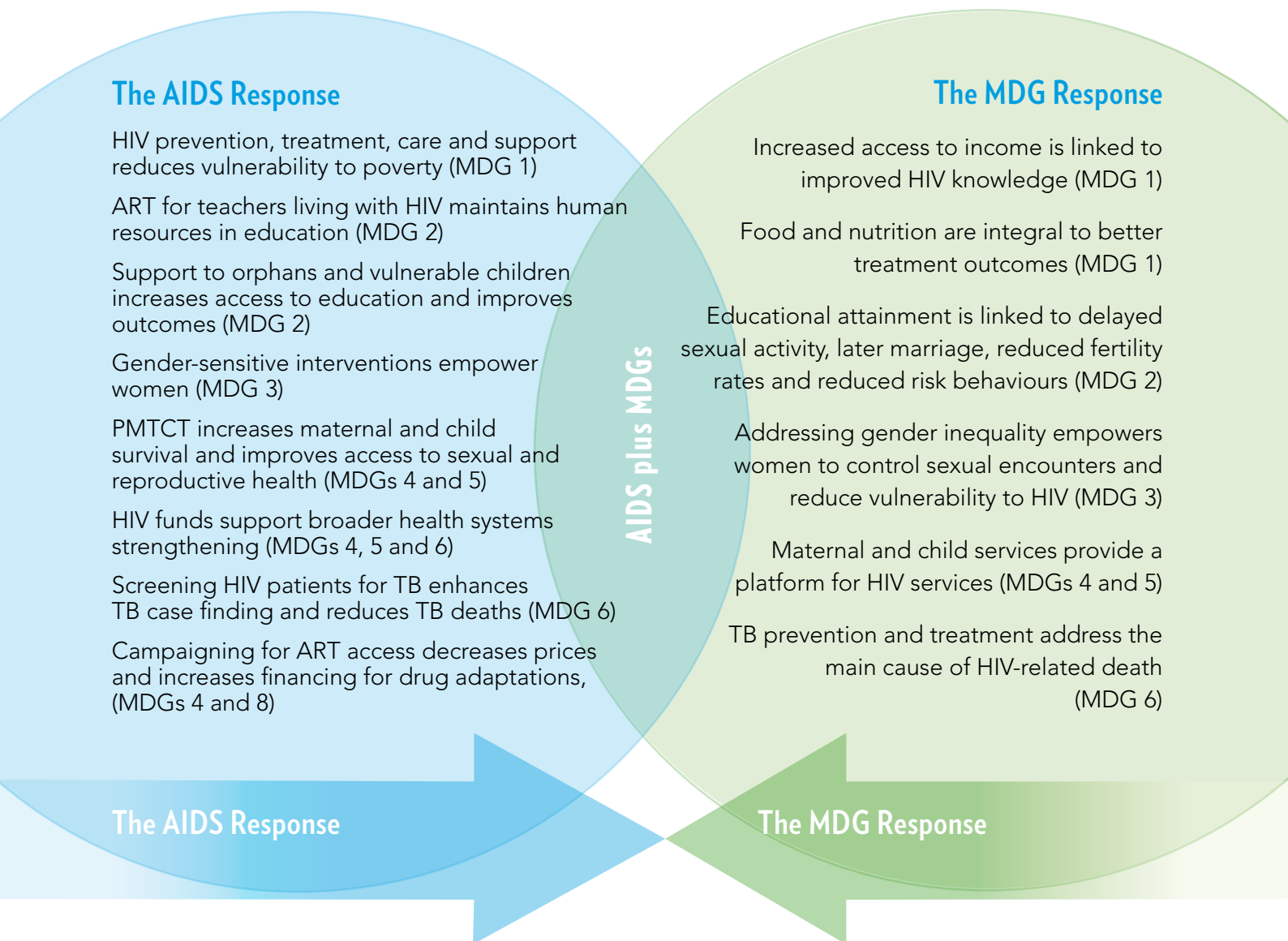
And HIV-affected households that preserve their productivity and earning power as a result of improved access to ART avoid the need to withdraw children from school to earn income or assume domestic responsibilities.

Conversely, efforts to meet the MDGs support the AIDS response. For example, progress towards MDGs 1, 2 and 3—**hunger and poverty reduction, universal education** and **gender equality**—helps reduce the HIV vulnerability of women and girls. Food insecurity can lead to coping behaviours such as selling assets, removing children from school, migrating and engaging in transactional sex, increasing exposure to HIV. Educational attainment is directly correlated with delayed sexual debut and reduced sexual risk behaviours,¹² and empowering women and girls enables them to take steps to reduce their risk of acquiring HIV.

Recent studies in Malawi and Tanzania demonstrate that conditional cash transfer programmes, which promote gender equality and empowerment, reduce the risk that women and girls will become infected.¹³ In addition, expanded **sexual and reproductive health services**, the focus of MDG 5, are accelerating progress towards prevention of mother-to-child transmission (PMTCT) of HIV and strengthening primary HIV prevention services for women.¹⁴

As the figure below illustrates, the synergies between HIV and other MDGs flow both ways. In many contexts, achieving MDG 6 is highly conditioned by progress on other MDGs. Fundamentally, the AIDS response must be leveraged with efforts to achieve the other MDGs. And in turn, we must find entry points in efforts to achieve other MDGs more systematically through integration with the AIDS response.

A two-way relationship that makes sense



2. Investments in AIDS plus MDGs stretch to more people

The 2008 Accra Agenda for Action reinforced the international community's commitment to aid effectiveness. A key step in translating this commitment into action is to take a more thoughtful, integrated approach to the MDGs, avoiding the unnecessary transaction costs and inefficiencies associated with the uncoordinated pursuit of the MDGs.

It is now more important than ever to make the most of existing resources, building on mutually reinforcing responses and improving value for money. It is critical to avoid parallel processes and service programmes that address individual MDGs if we are to maximize efficiencies and sustainability.

In Ethiopia, AIDS funding helps expands primary care across communities

A strong, results-driven alliance between the Ethiopian government and its key development partners is producing win-win results by channelling AIDS resources to strengthen the country's health systems. Ethiopia is frequently held up as an example of a country making significant strides towards the MDGs, and this blending of AIDS into the mix is cited as a contributing factor.

Between 1990 and 2008, child mortality in Ethiopia declined by 47%, and maternal mortality by 39%, with the most pronounced change occurring between 2004 and 2008. This drop coincided with the government's move to direct more than \$300 million in PEPFAR and Global Fund HIV dollars towards comprehensive health systems strengthening while also pursuing core HIV targets.

The country's Health Sector Development Plan (HSDP III) managed a fundamental reorganization of health services that centred on decentralization, integration and task shifting. Not only has this approach decreased the burden on health facilities, but it has also enabled the health system to reach deep into individual communities through a flagship health extension program—a community-based initiative that stresses health promotion, disease prevention and selective curative services.

As a result, the number of health care facilities in Ethiopia has blossomed from just over 3,500 in 2004 to more than 17,000 today. Coverage is provided by some 33,000 Health Extension Workers, whose contributions have transformed primary health care, maternal and child survival and HIV-related services.

Since 2006, antenatal care coverage rose from 50% to 68%, and the percentage of fully immunized children grew from 55% to 66%. Coverage for antiretroviral therapy had reached 57% by the middle of this year—a rate that surpasses most African countries.

Such success would not have been possible without the political will, unwavering commitment and visionary leadership of the Ethiopian government. The health system is on solid footing with arrangements for complementary utilization of available funding—including AIDS—that will allow it to continue reaping benefits and produce return on initial investments.

Source: Ministry of Health of the Federal Democratic Republic of Ethiopia, HIV/AIDS and the health-related Millennium Development Goals: The experience in Ethiopia. August 2010.

When AIDS is kept in isolation and treated as a unique, but disconnected, infectious disease, it drains human and financial resources from broader public health services. The *AIDS plus MDGs* agenda envisions strategic, well-planned efforts to use health and development funding to maximum advantage, capitalizing on approaches that capture synergies, build strong and durable health systems, and achieve advances on multiple development priorities simultaneously. This agenda prioritizes breakthrough strategies that achieve bidirectional benefits and multiplier effects across several MDGs and across a vast cohort of people with diverse health needs.

3. AIDS plus MDGs strengthens systems and encourages integrated and holistic service delivery

The categories commonly used in development practice, while useful, do not match the lived reality of the individuals and communities the MDGs seek to benefit. A person living with HIV certainly requires HIV services, but like any other person, he or she invariably has a host of other needs that a well-planned service system will address. Integrated service delivery places the person at the centre of a continuum of health services and encourages care coordination to improve health outcomes.

By taking the AIDS response further out of isolation, it is possible to leverage AIDS programmes to achieve even broader gains. For example, PMTCT coverage not only helps prevent newborns from becoming

infected, it also provides an entry point to deliver a continuum of integrated health services for the whole family, such as counselling for sero-discordant couples, HIV testing for siblings, identification of high-risk pregnancies and the detection of diseases such as tuberculosis, congenital syphilis and sexually transmitted infections. PMTCT services can lead to uncovering and responding to sexual and domestic violence and can meet the need for family planning among HIV-positive women.

While PMTCT coverage has shown considerable progress, rising from 10% to 45% between 2004 and 2008, more needs to be done to scale up so that countries can take full advantage of the linkages between mother-to-child transmission and other health services as they work towards the MDGs.¹⁵

A focus on continuum of care and family-centred approaches can provide strong drivers for service integration, whilst health system strengthening can be central to an “enabling environment.” Numerous studies have confirmed that integrating HIV and other health services can improve service coverage, quality and utilization rates, leading to significant public health benefits and more efficient use of resources.¹⁶ In India, integration of HIV counselling and testing services into a sexual and reproductive health and rights (SRHR) clinic run by the Child In Need Institute increased uptake of HIV counselling and testing alongside SRHR services. Concerns that integrating HIV services would displace clients receiving SRHR services proved to be unfounded.¹⁷

AIDS plus MDGs in action: Rwanda's results

Rwanda has been considerably successful in strengthening a comprehensive HIV response that benefits the broader health sector and beyond. The leadership has engaged key development partners in flexible funding approaches, addressing a range of country-level health priorities in a climate of shared accountability.

Rwanda's Global Fund Round 5 proposal was specifically focused on HIV and AIDS and health systems strengthening with a goal to improve financial accessibility and quality of health care delivery for the poor, people living with HIV and members of most-at-risk groups. The Global Fund grant has been deployed to finance a community-based health insurance programme providing primary health care (PHC) services to nearly 3 million poor Rwandans, orphans and vulnerable children and people living with HIV. The programme also extends to providing technical assistance to insurance providers, training to approximately 5,800 health workers and electricity to 37 health centres.

The *AIDS plus MDGs* approach is delivering positive outcomes at the community level by also introducing a widespread model of “basic HIV care” that includes voluntary counselling and testing, PMTCT and prophylactic therapy. A Family Health International study of 30 PHC centres before and after the introduction of the programme showed an associated increased use of general PHC services, with increased coverage rates of new antenatal care clients from 68% to 81%, increased vaccination coverage rates for children from 79% to 87% and significantly increased coverage of reproductive health services.

These findings were attributed to improved health worker capacity and health facility infrastructure at sites incorporating HIV care. The study has also been used to refute the claim that HIV programmes produce adverse effects on non-HIV service delivery. Similarly, in 2008, the Ministry of Health reported increased use of maternity services in health facilities offering PMTCT. At health facilities offering PMTCT as part of integrated services, the number of assisted deliveries was reported to be 16% higher than the national average of 45%.

Sources: Price J, Leslie JA, Welsh M, Bingawaho A. Integrating HIV clinical services into primary health care in Rwanda: a measure of quantitative effects” *AIDS Care* 21:5. 2009.
Ministry of Health of Rwanda. Annual Report 2008. Kigali, Rwanda: GoR (70). 2009.

Increased ART access is helping minimize the loss of health workers due to illness or death, benefiting the full complement of health priorities.¹⁸ Refurbishment of health facilities as a result of AIDS funding has the potential to improve service infrastructure for primary care generally. And the increased laboratory capacity and improved commodity procurement and supply management systems resulting from AIDS funding can be leveraged to benefit health systems overall¹⁹

4. AIDS plus MDGs *promotes action to address common policy barriers*

Situating the AIDS response within the broader health, development and human rights environment encourages the foresight and careful planning needed to capture synergies and promote focused action to address common policy challenges. Issue-specific and silo approaches can be replaced with more joined-up policy and coordinated, multi-sector planning and resource allocation.

Just as building and remunerating the health workforce is a cross-cutting priority that demands a comprehensive and strategic approach, so too are issues of commodity procurement and logistics—including community-based distribution systems—health care financing, restrictions on sexuality education and services and involvement of most-at-risk populations in service planning and delivery. Removing common barriers unblocks progress on AIDS as well as tuberculosis, malaria, family planning, safe delivery and other health issues.

Concerted action on international trade regimes, patent laws and patent pooling presents opportunities to increase investments in research and development, reduce costs and open trade channels for more equitable access to a range of essential health and development commodities. A joined-up approach to international trading rules also supports the MDG on global partnership (MDG 8).

These actions will be particularly important for driving progress towards universal access through the development of a new generation of HIV treatment responses—simpler and more effective drugs and diagnostics—that can be administered at community level. Simplified, decentralized HIV treatment services build stronger community health and social systems by bringing resources to the community, building capacity of community health workers and strengthening infrastructure, including procurement systems to increase access to essential commodities as well as prevention services.

In Nigeria, stronger health systems start in the community

AIDS plus MDGs is about thinking globally, but acting locally, scaling up interventions from the community level. In Nigeria, through its Global Fund Round 8 grant, primary health care (PHC) centres in rural areas are being restored, and health care workers are being trained to deliver a range of health services. Procurement, supply management and information systems are also being strengthened—with the intention that 925 PHC facilities will be renovated and functional over the next five years.

The country's Mid-wives Services Scheme has mobilised and deployed 2,488 midwives to 652 PHC centres since September 2009. Based on the AIDS cluster model strategy, the centres are clustered around a general hospital with capacity to provide emergency obstetric care. Preliminary reports show that where mid-wives are accessible, the proportion of deliveries attended by skilled birth attendants has risen to over 80%.

Nigeria is also home to one of the sites of the Millennium Villages Project (MVP), which now stretches across 10 countries. The Pampaida MVP is providing comprehensive health, education and poverty alleviation programmes to 20,000 residents in the State of Kaduna. Five years ago, few pregnant women in the village would go to a health centre to get an antenatal check up, and most would never return after their first visit. It was common that women gave birth at home, often attended by untrained help and no recourse to health care in case of an emergency.

These days, village health workers reach out to pregnant women, encouraging them to come to the local health clinic for routine check ups. Here, trained doctors and nurses provide quality health care and HIV testing.

In the first two years of the programme, the village saw a three-fold increase in women who have benefited from maternal and child health services. Only four deaths due to pregnancy-related complications were reported—a sharp drop from previous years.

The growing success of the programme has attracted other development investments to the area. The government of Kaduna has built a road into the village, and mobile telephony providers have installed a distribution tower.

Nigeria is demonstrating that achieving the MDGs in Africa's most resource-constrained settings can be done by empowering communities and investing simultaneously in an integrated set of services.

5. *AIDS plus MDGs capitalizes on the strength of movements for change*

The global AIDS response has depended on extraordinary grassroots energy, particularly of people living with HIV, and on diverse coalitions that have united in common cause. Collective engagement has generated political and financial commitments, supported rapid technological innovation and revolutionized the way services are designed and delivered. A case in point is the worldwide campaign for access to ART earlier this decade, which mobilized around and challenged the interpretation of global trading rules in countries as disparate as South Africa and Thailand.²⁰

Diverse groups also found a common focus in fighting the injustices perpetrated against those living with or vulnerable to HIV. *AIDS plus MDGs* can build on this approach for change. The MDGs offer numerous rallying points—from joint efforts merging AIDS, women’s rights, sexual health and other movements to combined movements for child and maternal health.

In contrast to earlier decades, when global health and international development often struggled for attention and resources, major new constituencies have arisen throughout the world to advocate for greater attention to the needs of low- and middle-income countries and emerging economies. The *AIDS plus MDGs* agenda does not represent the relinquishment of AIDS activism, but rather, it offers new opportunities to broaden these coalitions and forge new, even more effective approaches to development challenges. In this time of global financial austerity, we need to build on the successes of the AIDS response and move towards a fully funded MDG agenda—through existing and innovative sources of funding.

South Africa takes responsibility

In December 2009, President Zuma announced South Africa’s scaled-up response to HIV, heralding it as a new era of increased responsibility. Through the most ambitious testing campaign in the world, South Africa plans to test 15 million people for HIV. The country intends to offer comprehensive HIV services at all health facilities, increasing access to counseling, testing and treatment and wellness services for those who test positive.

This groundbreaking campaign is not just about delivering HIV-related services. Every person who enters a testing station anywhere in the country will also be able to access services related to hypertension, diabetes, anaemia and tuberculosis. Plans for integrated antenatal care will include PMTC services. The integration of PMTCT into broader health services is part of South Africa’s current push to reduce maternal and child mortality, and scaling up PMTCT services has also been identified as a top priority.

Offering PMTCT in antenatal clinics across the country harnesses available resources while addressing South Africa’s high maternal mortality rate. It is estimated that more than 50,000 lives could be saved by 2015 if maternal and child health interventions were implemented consistently.

The integrated approach launched by South Africa will advance progress in preventing HIV transmission, promoting maternal and family health, and preventing deaths in children. Consistent with a holistic approach, numerous ministries, development partners, and civil society are now engaged in a joint national effort to generate broad-based improvements in health outcomes for women and children.

6. *AIDS plus MDGs makes sure that MDG efforts are rights-based, inclusive and leave no one behind*

Commitment to a rights-based approach is a core value of the AIDS response and a major contribution of the AIDS movement to the broader development agenda. The insistence on a rights-based response recognizes the mutually reinforcing relationship between universal access, human rights, public health and development. The full engagement of those living with and affected by HIV, supportive legal frameworks and the protection of vulnerable populations has been critical to every success of the AIDS response and offers a model for other development challenges.

The struggle to protect and promote human rights is responsible for some of the signal achievements of the AIDS response. In a historic legal case in Thailand in 2002, two people living with HIV successfully challenged a pharmaceutical company’s patent on an antiretroviral drug, with the court ruling that the rights to life and to health outweighed the company’s property rights.²¹

The Millennium Declaration on Human Rights

“We will spare no effort to promote democracy and strengthen the rule of law, as well as respect for all internationally recognized human rights and fundamental freedoms, including the right to development.”

United Nations Millennium Declaration, Paragraph 24, 2000

The human rights orientation of the AIDS response applies directly to the global MDG campaign’s commitment to gender equality, universal primary education, the right to be free of poverty and the right for even the most marginalised to be protected from preventable disease and death.

Indeed, progress in the AIDS response is dependent on realization of rights in other domains. Enhancing women’s rights (MDG 3) potentially gives women greater power to control sexual encounters, reduce exposure to HIV, combat sexual and domestic violence—major risk factors for HIV—and access HIV treatment and other health services.

Likewise, working with partners to uphold the right to education (MDG 2) and ensure school access for girls is linked to delayed pregnancy, improved HIV and maternal and child health outcomes and women’s economic and political empowerment. Already, the promotion of rights-based approaches to AIDS has influenced efforts to address other health and development issues. In South Africa, the campaign for universal

A sign of China’s commitment

On World AIDS Day 2003, Chinese Premier Wen Jiabao announced the implementation of the “Four Frees, One Care” policy, marking a significant stepping-up of China’s commitment in the response to HIV and AIDS.

The Four Frees, One Care policy guarantees the provision of “four frees”—free antiretroviral treatment (ART) for those living with HIV; free voluntary counselling and testing for all Chinese, testing and ART for pregnant women for prevention of mother-to-child transmission; and free psychological care and education for those orphaned by AIDS. The provision of “one care” refers to services for people living with HIV, including welfare payments and employment support.

The creation and implementation of this policy is an important recognition of the rights of people living with HIV and vulnerable populations to access prevention and treatment services as part of their human right to health.

The government has also made bold commitments to achieve virtual elimination of mother-to-child transmission by 2015, and to halt new infections amongst people most at risk for HIV infection. The implementation of this scaled-up response to HIV has been backed up by significant increases in funding for China’s HIV response, with central funding for the AIDS response reaching 1.6 billion RMB in 2010.

China has also taken important recent action to sharpen the focus on human rights in the national response to AIDS, with the inauguration in July 2010 of the Red Ribbon Beijing Forum, which brings together representatives from government and civil society for open discussions on strengthening rights-based approaches to AIDS in China.

As well as providing significant impetus for achieving MDG 6, the implementation of the Four Frees, One Care policy will boost China’s efforts to achieve or exceed goals for universal primary education, reduce child mortality, improve maternal health and contribute to achieving the other MDGs.

education has been modelled on the successful drive by the Treatment Action Campaign to ensure access to treatment for people living with HIV.²²

If they are not doing so already, stakeholders in the AIDS response should begin working collaboratively with other movements to strengthen and leverage the synergies between HIV and other MDGs. In particular, they should pursue strategies to leverage investments in the HIV response in ways that engage the passion and know-how of affected communities, as well as that of women’s rights and youth coalitions.

SETTING AND MOVING THE AGENDA FORWARD

With only five years until the MDG deadline, this is the moment that countries are reviewing and developing their national development plans going forward to 2015. The time is ripe to push policymakers and donors towards efforts that strengthen health systems; stress social protection and justice; and integrate health, development and human rights priorities in the most powerful and effective ways.

The historic opportunity presented by the shift in global policymaking from the exclusive G8 to the more expansive G20 must be seized. The Group of 20 includes an emerging set of countries—including Brazil, China and India—who bring their unique experiences to the governance of global challenges. Encouraging the G20 to add development concerns to its budding mandate and to adopt a different and more holistic approach to the MDGs—as illustrated by the *AIDS plus MDGs* agenda—could make the difference between success and failure.

Now is the time for the global community to take concrete steps to implement the *AIDS plus MDGs* agenda.

First, in the context of honouring all development financing commitments, countries should sustain and increase their financial contributions to HIV.

Second, to successfully design and implement cross-MDG strategies and transfer lessons across fields of expertise, institutional barriers to multi-sectoral action will need to be identified and overcome.

Third, *AIDS plus MDGs* will succeed only if all countries and partners develop even stronger partnerships and ensure that cross-MDG strategies are adequately reflected in national and sectoral development plans and Poverty Reduction Strategy Papers.

The MDG Summit is a singular opportunity to raise the salience and significance of the *AIDS plus MDGs* approach—for example, to promote the inclusion of specific *AIDS plus MDGs* actions in the UN Secretary-General's Action Joint Action Plan to Improve the Health of Women and Children.²³

Ultimately, the success of the *AIDS plus MDGs* agenda depends on its traction beyond the MDG Summit.

The 2011 UNGASS review—and the renewal of the Political Declaration—provides a political target to reinforce the agenda. In advance of the comprehensive review of progress in the global response to AIDS by the United Nations General Assembly in 2011, national partners should utilize the process of reviewing progress in reaching country targets for universal access to identify *AIDS plus MDGs* opportunities.

Given the centrality of gender to the *AIDS plus MDGs* agenda, it will be important to ensure that the new UN Women agency accounts for approaches that integrate all of the MDGs within its mandate.

The 2010 MDG Summit is a major opportunity to shape a future where the AIDS response and the MDG responses come together with renewed energy and synergy. Coming together as one can yield concrete results across the comprehensive development agenda for generations to come.

AIDS plus MDGs: managing risks

The *AIDS plus MDGs* approach is not without its detractors. Some are concerned that further integration of HIV responses will lead to a loss of focus, risking hard-won and fragile gains made to date. Others are concerned that linking to the MDGs will detract attention from the special needs of key affected populations.

These risks are real, but can be mitigated with safeguards—for example, supporting performance-based financing, conditioning integration and collaboration on the adoption of rights-based and inclusive approaches and developing an evidence-informed approach to demonstrate the positive impact HIV funding and programming can have on health systems and to mitigate against unintended or negative impacts.

Finally, listening and engaging with critics will be critical in positioning AIDS as a driver of health systems strengthening.

References

- 1 Ban Ki-moon, UN Secretary-General, speaking at the General Assembly High-Level Meeting on HIV/AIDS. New York, June 2008.
- 2 UN. *The Millennium Development Goals Report 2010*. 2010.
- 3 UN General Assembly. *Progress made in the implementation of the Declaration of Commitment on HIV/AIDS and the Political Declaration on HIV/AIDS*. New York, 2010.
- 4 Independent Commission on AIDS in Asia. *Redefining AIDS in Asia—Crafting an effective response*. New Delhi, March 2008.
- 5 Henry J. Kaiser Family Foundation, UNAIDS. *Financing the response to AIDS in low- and middle-income countries: International assistance from the G8, European Commission and other donor governments in 2009*. 2010.
- 6 UNICEF. *State of the world's children special edition: Celebrating 20 years of the convention on the rights of the child*. New York, 2009.
- 7 Stuckler D, Basu S, McKee M. Drivers of Inequality in Millennium Development Goal Progress: A Statistical Analysis. *PLoS Med* 2010; 7(3).
- 8 Ndirangu J et al. *A decline in early life mortality in a high HIV prevalence rural area of South Africa: Associated with implementation of PMTCT and/or ART Programmes*. 5th IAS Conference on HIV treatment, pathogenesis and prevention, Cape Town, 2009.
- 9 Hogan M, Foreman K, Naghavi M, Ahn S, Wang M, Makela S, Lopez A, Lozano R and Murray C. Maternal mortality for 181 countries, 1980–2008: a systematic analysis of progress towards Millennium Development Goal 5, *Lancet* 375 (2010), pp. 1609-1623.
- 10 Middelkoop K. 5th IAS Conference on HIV Pathogenesis, Treatment and Prevention, Cape Town, Abstract WELBB 105, 22 July 2009.
- 11 Global Fund. *The Global Fund 2010: Innovation and impact*. <http://www.theglobalfund.org/en/publications/progressreports/2010/> (Accessed June 12, 2010).
- 12 Hargreaves JR, et al. Systematic review exploring time trends in the association between educational attainment and risk of HIV infection in sub-Saharan Africa. *AIDS* 22:403-414. 2008.
- 13 World Bank. *Malawi and Tanzania research shows promise in preventing HIV and sexually-transmitted infections*. 2010. Accessed on 2 August 2010 at <http://econ.worldbank.org/WBSITE/EXTERNAL/EXTDEC/0,,contentMDK:22649337~pagePK:64165401~piPK:64165026~theSitePK:469372,00.html>.
- 14 UN General Assembly (2010) op cit.
- 15 Dickinson C, Attawell K, Druce N. Progress on scaling up integrated services for sexual and reproductive health and HIV *Bulletin of the World Health Organisation* 87: 846-851. 2009.
- 16 Druce N, Nolan A. Seizing the big missed opportunity: Linking HIV and maternity care services in sub Saharan Africa. *Reproductive Health Matters* 15 (30): 190-201. 2007.
- 17 Makombe SD, Jahn A, Tweya H, Chuka S, Yu JK, Hochgesang M, Aberle-Grasse J, Pasulani O, Schouten EJ, Kamoto K, Harries AD. A national survey of the impact of rapid scale-up of antiretroviral therapy on health-care workers in Malawi: effects on human resources and survival. *Bulletin of the World Health Organization* 85(11):851-7. 2007.
- 18 Yu D, Souteyrand Y, Banda M, Kaufman J, Perriens J. Investment in HIV/AIDS programs: Does it help strengthen health systems in developing countries? *Globalization and Health* 4:8. 2008.
- 19 Pfeiffer J, Montoya P, Baptista A, Karagianis M, de Morais Pugas M, Micek M et al. Integration of HIV/AIDS services into African primary health care: Lessons learned for health system strengthening in Mozambique—a case study. *Journal of the International AIDS Society*. 13: 3. 2010.
- 20 <http://iss.sagepub.com/cgi/content/abstract/21/1/5>; Helen Schneider. On the Fault Lines; HPP Sripen and Walt on Thailand network; Ford et al. *Lancet* 363. 2004.
- 21 UNAIDS. *Courting rights, case studies in litigating the human rights of people living with HIV*. 2006. http://data.unaids.org/Publications/IRC-pub07/JC1189-CourtingRights_en.pdf?preview=true (Accessed June 14, 2010).
- 22 HLSP/UNAIDS. *Strengthening linkages between the AIDS response and the MDGs: A discussion paper for UNAIDS*. 2008.
- 23 UN. *Joint Action Plan To Improve the Health of Women & Children*. 2010. http://www.un.org/sg/hf/Joint_Action_Plan_En.pdf (Accessed June 14, 2010)

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