Scaling up access to HIV prevention, treatment, care and support:
The next steps
Scaling up access to **HIV** prevention, treatment, care and support: **The next steps**
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Foreword

AIDS has been with us for 25 years. In that time, it has grown from a little-known disease outside the mainstream of society to a global threat to development and security. HIV has destroyed the lives of millions of families and communities, and still it continues to spread. Its resilience to our efforts is due to its exceptional nature. AIDS touches on the taboos of many societies, allowing HIV to take root in society’s vulnerable groups. The virus increasingly targets young people, women and the impoverished as it spreads, exploiting their lack of economic, social and sexual power.

In the last five years I have witnessed a sea change in political commitment to the AIDS response. Starting with the Declaration of Commitment on HIV/AIDS in 2001, AIDS has increasingly received the political and financial attention it deserves. On 2 June 2006, the UN General Assembly made a new commitment to scale up towards the goal of universal access to comprehensive HIV prevention programmes, treatment, care and support by 2010. This commitment included agreement to increase efforts to tackle the major obstacles to scaling up, which were identified by 126 country consultations and seven regional consultations facilitated by UNAIDS.
This pamphlet reviews that country-driven process and identifies the next steps on the road towards universal access. We must turn again to countries for the implementation of our commitments. It is at country level that governments, civil society, faith-based organizations, the private sector and people living with HIV will together set a series of measurable targets for 2010 and then strive to achieve them. Each and every one of us has a stake in the success or failure of these efforts to end AIDS. This goal may be many years away, but I am confident that we can swiftly convert universal access from a dream to reality. As Dr. Peter Piot, the Executive Director of UNAIDS, recently said: “Only universal access can keep this epidemic from engulfing the next generations. To fail now would be unforgivable.”

Michel Sidibe
Director, Country and Regional Support Department
Joint United Nations Programme on HIV/AIDS
The world has entered a major new phase in the effort to end AIDS. On 2 June 2006 in the face of massive challenges and the continuing spread of HIV, the UN General Assembly committed to scale up towards the goal of universal access to comprehensive HIV prevention programmes, treatment, care and support by 2010\(^1\).

Underneath this headline commitment of the 2006 Political Declaration on HIV/AIDS are pledges to tackle the major obstacles standing in the way of universal access: poor planning and coordination, insufficient financial resources, inadequate human capacity, weak systems, expensive medicines and prevention commodities, lack of respect for human rights, stigma and discrimination and insufficient accountability for results.

These obstacles were identified during country and regional consultations facilitated by the Joint United Nations Programme on HIV/AIDS (UNAIDS) in early 2006. This publication takes a closer look at the results of those consultations, introduces the reader to some of the people who participated in the process and discusses the challenges ahead.

Scaling up towards universal access is an extraordinary commitment by world leaders, signalling the political will to devote the resources and energy required to end AIDS. The actions taken by all stakeholders in the coming months and years will ultimately determine how far we will travel along this road by the end of 2010. UNAIDS will continue to support countries as they work to fulfil their commitments. An important first step will be the setting of national targets on prevention, treatment, care and support to be achieved by 2010.

\(^1\) United Nations (2006a).
2006 Political Declaration on HIV/AIDS

The declaration commits UN Member States to “pursuing all necessary efforts to scale up nationally driven, sustainable and comprehensive responses to achieve broad multisectoral coverage for prevention, treatment, care and support, with full and active participation of people living with HIV, vulnerable groups, most affected communities, civil society and the private sector, towards the goal of universal access to comprehensive prevention programmes, treatment, care and support by 2010” (paragraph 20).

Member States also reaffirmed their commitment to fully implement the 2001 Declaration of Commitment on HIV/AIDS and further strengthened international commitment on AIDS by:

- pledging to set, in 2006, national targets for prevention, treatment, care and support—including interim targets for 2008—that reflect the commitments within the 2006 Declaration and the urgent need to scale up significantly towards the goal of universal access by 2010;

- pledging to provide the highest level of commitment to ensure that costed, inclusive, sustainable, credible and evidence-based national HIV/AIDS plans are funded and implemented with transparency, accountability and effectiveness, in line with national priorities;

- recognizing the UNAIDS estimates that US$ 20–23 billion will be required annually by 2010 to fund sufficiently scaled-up AIDS responses, and committing countries to reduce the current funding gap by making new resources available from domestic and international sources in a way that is more predictable, sustainable and aligned with national plans and strategies;

- emphasizing the need to strengthen policy and programme linkages and coordination between AIDS, sexual and reproductive health, national development plans and strategies, including poverty eradication strategies, and to address, where appropriate, the impact of AIDS on national development plans and strategies;
pledging to increase capacity of human resources for health, and committing additional resources to low- and middle-income countries for the development and implementation of alternative and simplified service delivery models and the expansion of community-level provision of comprehensive AIDS, health and other social services;

reaffirming the right to use agreed trade flexibilities (e.g. the World Trade Organization’s Agreement on Trade-Related Aspects of Intellectual Property Rights), and resolving to assist low- and middle-income countries to employ these flexibilities;

committing to an intensification of efforts to eliminate all forms of stigma and discrimination against people living with HIV and members of vulnerable groups, and to ensure their full enjoyment of all human rights and fundamental freedoms, in particular their access to comprehensive AIDS programmes;

pledging to eliminate gender inequalities, gender-based abuse and violence; to increase the capacities of women and girls to protect themselves from HIV infection, principally through the provision of health care and services, including sexual and reproductive health; to provide women full access to comprehensive information and education, interventions to prevent mother-to-child transmission of HIV and “life-long” antiretroviral therapy;

committing to address the rising rates of HIV infection among young people through the implementation of comprehensive, evidence-based prevention strategies that promote responsible sexual behaviour, including the use of condoms; and

pledging to promote access to HIV and AIDS education, information, voluntary counselling and testing and related services, with full protection of confidentiality and informed consent, and to promote social and legal environments that are safe for voluntary disclosure of HIV status.
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 not a new initiative. It is a process that builds on past initiatives and infuses existing initiatives with new momentum.

Universal access is also more complex than 100% coverage of services—an ambitious goal for any country to achieve. As well as setting country-specific targets, national partners must determine a fair and sustainable path to reaching their targets. In scaling up towards universal access, countries must ensure that nobody is left behind. Our efforts should therefore be:

- **equitable**: information and services must be made available to rich and poor, women and men, young and old, mainstream society and vulnerable groups, including men who have sex with men, sex workers and injecting drug users;

- **accessible**: locally relevant and meaningful information and services need to be available when and where people need them, and they need to be able to use them without fear of prejudice or discrimination;

- **affordable**: cost should not be a barrier to commodities (e.g. medicines and diagnostics, condoms) and services (e.g. harm reduction) that exist now, and to what we hope will be developed in the future (e.g. microbicides and vaccines, and new medicines);
UNAIDS

- **comprehensive**: prevention, treatment, care and impact mitigation must be linked and planned and delivered with the full inclusion of people living with HIV, civil society, faith-based organizations, private sector, international partners and government; and

- **sustainable**: HIV is a lifelong challenge requiring sustained action for preventing new infections and saving and improving the quality of the lives of those with HIV; services must be available throughout people’s lives rather than as one-off interventions. New technologies and approaches must continue to be developed to meet ever-changing needs.

![Building momentum – 25 years of responding to AIDS](chart)

- First cases of unusual immune deficiency are identified among gay men in the USA and a new deadly disease noticed
- The Human Immunodeficiency Virus (HIV) is identified as the cause of AIDS
- Global Network of People Living with HIV/AIDS (GNP+) (then International Steering Committee of People Living with HIV/AIDS) founded
- The World Health Organization launches the Global Programme on AIDS
- Highly Active Antiretroviral Treatment launched
- Brazil becomes the first developing country to provide antiretroviral therapy through its public health system
- Scientists develop the first treatment regimen to reduce mother-to-child transmission of HIV
- The first therapy for AIDS—zidovudine, or AZT—is approved for use in the USA
- In Africa, a heterosexual AIDS epidemic is revealed
- WHO and UNAIDS launch the "3 x 5" initiative with the goal of reaching 3 million people in developing world with antiretroviral treatment by 2005
- The Global Fund to Fight AIDS, Tuberculosis and Malaria launched
- The UN General Assembly Special Session on HIV/AIDS
- President Bush announces PEPFAR
- International AIDS Conference in Durban
- Drug Access Initiative launched by UNAIDS in Africa

![Graph](chart)

- People living with HIV
- Children orphaned by AIDS in sub-Saharan Africa
An exceptional challenge

AIDS is an exceptional crisis and requires an exceptional response.

Around the world, it is estimated that some 38 million people are living with HIV. Some 4 million of these were new infections in 2005. Nearly 3 million people lost their lives to the disease in 2005, and at least 25 million lives have been lost to AIDS already.

AIDS is both a short-term emergency and a long-term development crisis that cripples economies and social systems, and targets people in their most productive years—teachers, health-care workers, business people and community leaders.

“The AIDS pandemic is as serious a threat to humanity’s prospects for progress and stability as global warming or nuclear proliferation. It is exceptional in its scale, complexity and the consequences across generations, in severity, longevity and its impact. It can only be defeated with sustained attention and the kind of ‘anything it takes’ resolve that Member States apply to preventing global financial meltdowns or wars”²,³.

Peter Piot,
Executive Director of UNAIDS

Nearly half of people infected with HIV are women⁴. AIDS is growing rapidly among young women, largely due to their lack of information and power. Globally, young women represent over 60% of all 15–24-year-olds living with HIV, leading some observers to warn that women are becoming an “endangered species” as a result of AIDS⁵. Not only do women bear an enormous burden of infection, but they are first-line care providers for the sick and orphans.

² IRIN PlusNEWS (2005).
⁴ UNAIDS (2006a).
⁵ ODI/UNFPA (2005).
A long way from universal access

Antiretroviral drugs still reach only one in five who need them.

In 2005, only 0.6% of adults in low- and middle-income countries obtained an HIV test\(^6\).

Only 9% of HIV positive pregnant women are receiving antiretroviral prophylaxis to prevent infection of their unborn child.

Surveys indicate that fewer than 50% of young people are knowledgeable about HIV.

Only 9% of men who have sex with men, and fewer than 20% of injecting drug users, received any type of HIV prevention service in 2005.

Less than 10% of the 12 million children orphaned by AIDS in sub-Saharan Africa receive public support\(^7\).

Yet these figures cover only the most direct consequences of the epidemic. Behind the statistics are ordinary people:

- people who face stigma and discrimination because they are living with HIV;
- people who may already be struggling under poverty and conflict;
- people caring for those with an AIDS-related illness;
- children whose parents have died of AIDS; and
- people like Lillian Mworeko, mother, widow and HIV positive activist (see box).

\(^6\) UNAIDS (2006a).
\(^7\) UNAIDS analysis of the 2005 Country UNGASS Reports.
Building momentum

In the five years since UN Member States made a Declaration of Commitment on HIV/AIDS at the 2001 Special Session of the UN General Assembly, the global AIDS response has steadily grown and gained momentum. The Global Fund to Fight AIDS, Tuberculosis and Malaria is now providing low- and middle-income countries with additional financing for AIDS and other diseases, the World Bank provides large-scale grants through its Multi-country AIDS Program, and individual high-income countries have significantly increased their bilateral assistance, supplementing increasing public sector budget allocations in low- and middle-income countries. Increased funding has also been mobilized for research and trials of vaccines, microbicides and other new technologies.

Civil society advocacy, special pricing by pharmaceutical companies for low-income countries, increased generic competition and local production, and negotiations facilitated by philanthropic foundations have slashed the prices of first-line antiretroviral medicines and increased their availability. The “3 by 5” initiative built on these developments. Although it fell short of its target of 3 million people receiving antiretroviral treatment in low- and middle-income countries by the end of 2005, “3 by 5” definitively demonstrated the feasibility of administering antiretroviral therapy in resource-limited settings, catalyzed action in many countries and helped identify strategies for overcoming bottlenecks to scaling up access to treatment.
A renewed emphasis on the importance of HIV prevention has reinforced the importance of a comprehensive response. Antiretroviral treatment cannot prevent the spread of HIV, and universal access to treatment requires a significant reduction in the rate of new infections. The UNAIDS policy paper *Intensifying HIV prevention* provides a framework for scaling up evidence-informed HIV prevention programmes within a response that includes treatment, care and support for those infected and affected by HIV.

In early 2006, a review⁸ found that progress was considerable towards achieving the goals of the 2001 Declaration of Commitment on HIV/AIDS, but also that many countries have so far failed to fulfil their pledges. Progress is uneven among countries and regions, and across the various targets and milestones. Some countries have made great strides in expanding access to treatment, but little progress in bringing HIV prevention programmes to scale. Other countries, although experiencing a reduction in national HIV prevalence, are making only slow progress on treatment.

In view of this, pressure built throughout the second half of 2005 to redouble global efforts on AIDS. At the July 2005 Gleneagles Summit, the G8 countries (and then all nations at the World Summit in September 2005) committed to coming as close as possible to universal access to treatment for all those who need it by 2010. Then, on 23 December 2005, the UN General Assembly decided to convene a High Level Meeting on AIDS, and called on UNAIDS to facilitate inclusive, country-driven processes to identify common obstacles to scaling-up, and to make recommendations for overcoming these obstacles in an assessment for consideration at the High Level Meeting. A particular emphasis was placed on putting countries more squarely in command of their own development programmes. The Monterrey Consensus and the Development Assistance Committee of the Organisation for Economic Co-operation and Development (OECD) have set standards and criteria for alignment and harmonization, which have been applied to national AIDS responses through the “Three Ones” principles and the recommendations of the Global Task Team on Improving AIDS Coordination among Multilateral Institutions and International Donors.

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The people behind the statistics: A mother from Uganda

Lillian Mworeko is an HIV positive activist from Uganda. Two months after her child was born her husband was diagnosed with AIDS. Since her husband’s death, Lillian has been working to raise the voice of people living with HIV through local and national nongovernmental organization work. Today, Lillian is the East Africa Regional Coordinator for the International Community of Women Living with HIV/AIDS. She was a member of the multi-partner Global Steering Committee that advised UNAIDS as it developed its assessment on scaling up towards universal access.

“I really crashed after Alex’s death. Everything seemed hopeless. I remained depressed until I started working in the field. It changed my life. I’ve travelled everywhere, worked with a lot of different people with AIDS, and in the process, I’ve become a lot more open, stronger, and more self-aware.”

From December 2005 to April 2006, thousands of people came together in 126 country consultations and seven regional consultations to identify obstacles to universal access and to propose solutions. A Global Steering Committee identified global-level actions, provided insights and inspiration, and acted as a political sounding board. A broad range of stakeholders—including governmental and nongovernmental organizations, aid donors, financing institutions, health experts, people living with HIV and faith-based groups—participated in this unprecedented process.
Key messages from country and regional levels

There is no single AIDS epidemic. The spread of HIV is as diverse as the societies it infects. Locally tailored prevention, treatment, care and support interventions are crucial to respond to epidemics that vary in their intensity, pace and impact in each country.

As country consultations examined local obstacles to universal access, a number of common issues emerged. It is clear that many low- and middle-income countries lack the management tools, financial resources, human capacity, public systems and accountability mechanisms required to double or triple the coverage of their AIDS programmes. Medicines, diagnostics and prevention commodities (such as female condoms) are still too expensive for these countries, and insufficient respect for the human rights of people living with HIV and those most vulnerable to infection is blocking uptake of available services. Regional and global consultations focused on developing strategies to improve assistance to countries struggling to overcome these obstacles.

photo credit: UNAIDS/L.Taylor
Rights

People living with HIV, women and most-at-risk populations

Stigma and discrimination of people living with HIV and those most-at-risk of infection—such as sex workers, injecting drug users and men who have sex with men—and the inequality faced by women and girls were cited in almost every consultation as major barriers to accessing HIV prevention and AIDS treatment and care. Even when these services are available, the misconceptions surrounding AIDS makes many people afraid to seek out information and help. For example, the consultation in Pakistan noted that most-at-risk populations do not have sufficient legal status and are either discriminated against or feel threatened in accessing AIDS services. Participants identified an overwhelming need for supportive and protective legislation and programmes.

“I am not a victim. I am a woman with brains and skills, a woman with the will and zeal to live. But if nothing is done, if I do not have access to life saving medicines, then I would become a victim of injustice, a victim of inequality, a victim of neglect. I would become a victim of bad policies, a victim of AIDS.

I do not want to be a figurehead. I do not want to die or pass this virus on to my baby. I want to live. I want access to treatment, access to life. What we need in Africa isn’t stigma or discrimination, but support to live a meaningful qualitative life and contribute our quota to the development of our country, our continent and the world at large.”

Morolake Nwagwu,
Project Director, Positive Action for Treatment Access, Nigeria and member of the Global Steering Committee
The **Latin America** regional consultation identified homophobia and gender inequalities as major obstacles in the uptake of services, and called for stronger legislation to counter this. In **Ghana, Ethiopia** and **Macedonia**, stigma was cited as a significant barrier to uptake of voluntary counselling and testing services. Reports from **Barbados, Burundi, Cape Verde, Eritrea, Guatemala, India, Rwanda, Sierra Leone, Somalia, The former Yugoslav Republic of Macedonia, Trinidad and Tobago, Ukraine, Zambia** and **Zimbabwe** also reported specific barriers to services for people in vulnerable groups. The **Ghana** and **Lebanon** consultations highlighted the special situations faced by migrants and refugees, and called for these groups to access and use prevention commodities and strategies, as well as sexual and reproductive health interventions.

**What is civil society?**

In a broad sense, the term refers to any nongovernmental sector, group or individual, including the private sector. In AIDS work, civil society generally refers to people living with HIV and their groups or networks, AIDS service organizations, community-based organizations, faith-based organizations and other nongovernmental organizations.

Consultation participants called for the reform of laws, policies and practices that discriminate against these groups, and that additional resources—both financial and human—be targeted towards the provision of legal and programmatic support to help people in these groups avoid HIV infection, or if already living with HIV, receive treatment, care and support.

The **Botswana** consultation noted that stigma and discrimination inhibited access at all levels of the response—from the uptake of counselling and testing, interventions to prevent mother-to-child transmission of HIV, adherence to AIDS treatment and even support and care for orphans and vulnerable children, where families are too ashamed to bring children in for registration. Other human rights violations
raised by consultations included employment and housing discrimination faced by people living with HIV, and the denial of inheritance rights to women following the death of their husband from AIDS.

Numerous consultations identified user fees for health and education as an obstacle to access, especially for people living below the poverty line. Even small user fees can impose a significant financial burden on individuals and families and undermine adherence to HIV treatment regimens and the use of prevention commodities. China has been demonstrating leadership in this area with the adoption of the “Four Frees and One Care” policy, providing free antiretroviral treatment to AIDS patients who are rural residents or people with financial difficulties living in urban areas. Somalia and Suriname are both undertaking similar trials to this effect. Botswana, Brazil, Ethiopia, Senegal, Thailand, the United Republic of Tanzania and Zambia have all adjusted their health financing policy to eliminate user fees for HIV treatment at the point of service\(^9\).

The low status of women in many societies is fuelling a “feminization” of the epidemic. The proportion of infections among women is increasing rapidly in many countries. By the end of 2005, 17.5 million women were living with HIV, or 46% of the global total of 40.3 million infections. In sub-Saharan Africa, women now comprise 57% of the total number of people living with HIV\(^{10}\). In younger age groups, girls predominate by as many as six to one.

\(^{10}\) UNAIDS (2006a).
Joining forces in the Caribbean

Since its formation in January 2001, the Pan-Caribbean Partnership against AIDS (PANCAP) has been working to reduce the prices of antiretroviral drugs in the region, as part of the Accelerating Access Initiative. Some countries, like Barbados and the Bahamas, are now close to providing treatment to all those in need, but unbridled stigma and discrimination is reducing the effectiveness of prevention efforts. PANCAP now considers stigma and discrimination a “flagship” issue for the Caribbean, which is the most affected region outside of sub-Saharan Africa. As part of a PANCAP project, sports champions and cultural icons are speaking out against stigma.

PANCAP benefits from a harmonized pool of resources by virtue of its regional composition, described as “a conglomerate of interests, not just a group of government entities.” Members include national governments, nongovernmental organizations, businesses, schools, faith-based organizations, AIDS service organizations and networks, intergovernmental organizations, UN entities and bilateral donors. Together as PANCAP, these partners provide vision and direction, coordinate activities, build public awareness and partner capacity, increase resource flows, monitor programme impact and avoid duplication.

The country consultation in Botswana reported that low economic status and inequitable gender relations deny women decision-making power in sexual matters, increasing their vulnerability to HIV infection. In Lesotho, women are legally classified as minors and so are deprived of important means to protect themselves. In many settings, marriage and women’s own fidelity are not enough to protect them from HIV infection. Among women surveyed in Harare (Zimbabwe), Durban and Soweto (South Africa) 66% reported having one lifetime partner and 79% had abstained from sex at least until the age of 17, yet 40% of the young women were HIV-positive. Participants at the Trinidad and Tobago consultation

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highlighted this fact, and called for increased access to female condoms as one way to strengthen women’s control over their sexual health.

Country consultations in every region called on governments to recognize the demographic implications of high infection rates in girls and women, their relationship to political rights, and their impact on vital national resources, like food production and population health. In Pakistan, participants reported that gender discrimination was blocking access to HIV preventive care and general health services, while the Albania consultation called for clear policies to address the needs of women and young girls. Participants at the Bangladesh meeting called for improved access to sexual and reproductive health interventions.

Based on the results of the consultations, UNAIDS called on the international community to better protect and promote the HIV-related human rights of people living with the virus, women and children, and people in vulnerable groups, and ensure that they are centrally involved in all aspects of the response. Specific recommendations in the UNAIDS assessment included these.

- National governments and international donors should prioritize funding for social mobilization campaigns in local languages to protect AIDS-related rights, and eliminate HIV-associated stigma and discrimination.

- National governments and international donors should increase funding to programmes that address gender inequalities, and should review and reform legislation where needed—including criminalization of domestic violence and harmful traditional practices, and ensuring property and inheritance rights of women and girls.

- National governments and international donors should increase funding for networks and organizations of people living with HIV to provide HIV prevention and treatment literacy campaigns in local languages aimed at increasing awareness and improving the delivery of HIV prevention and treatment.
National governments should establish and enforce legislation and policies to eliminate AIDS–associated stigma and discrimination against people living with HIV, injecting drug users, sex workers, men who have sex with men and other vulnerable populations.

Countries should promote, through global and national campaigns, the ideal that each person knows his or her HIV status and has access to basic AIDS information, counselling and related services, in a social and legal environment that is supportive and safe for confidential testing and disclosure of HIV status.

Countries should promote equitable access to AIDS interventions by reviewing their health system policies to reduce or eliminate user fees for AIDS–related prevention, treatment and care.

Money

*Predictable and sustainable financing and ensuring that no credible AIDS plan goes unfunded*

The amount of funding required to meet our commitments on AIDS and to come as close as possible to universal access to HIV prevention, treatment, care and support by 2010 is estimated by UNAIDS to be between US$ 20 and 23 billion. On the basis of current estimates of funding commitments, there will be annual resource gaps of as much as US$ 6 billion in 2006 and US$ 8 billion in 2007. To help close this gap, existing domestic financing and international donor commitments must be fulfilled and new ones made.

However, the international community cannot simply focus on the need for more funding. Countries must make the most of the finances that are currently available, and also ensure that funding is sustained over the long term. In the absence of a vaccine or a cure, AIDS treatment is a life–long commitment, and it will take many years to provoke the widespread change in behaviour required to significantly reduce the spread of HIV. Longer–term financial commitments, both in domestic budgets and through international cooperation mechanisms, are required.
Scaling up access to HIV prevention, treatment, care and support: The next steps

“In my view—and there is no diplomatic way to put this—the world is failing billions of people. Rich governments are not fighting some of the world’s most deadly diseases, because rich countries don’t have them. Let’s be frank about this. If these epidemics were raging in the developed world, people with resources would see the suffering and insist that we stop it.”

Bill Gates, Microsoft President, 2006 World Health Assembly

Low- and middle-income countries with strong economic growth and stable political situations must make greater domestic investments in their AIDS responses. But the burden of sustainability should not fall on the world’s poorest countries, and existing international financing mechanisms (e.g. the Global Fund to Fight AIDS, Tuberculosis and Malaria) do not offer long-term funding streams. Innovative new financing mechanisms (e.g. the airline solidarity contribution and the International Finance Facility) could provide a more stable flow of financing for low-income countries’ AIDS responses.

The Bahamas, Burkina Faso, Chad, Ethiopia, Ghana, Kenya, Kyrgyzstan, Lebanon, Malaysia, Republic of Moldova, Romania, South Africa, Tajikistan, Togo and Turkey were among the many consultations that highlighted insufficient or unpredictable financial resources as major constraints. The Nigeria consultation highlighted the importance of having estimates of national funding needs, a national AIDS account to track funds, and a national resource mobilization plan for increasing the level and predictability of funding.

The importance of improving coordination and harmonization of international and national efforts, and aligning international support to national priorities has been emphasized in numerous international statements and agreements, such as the Paris Declaration on Aid Effectiveness, the “Three Ones” principles and Global Task Team recommendations. The country consultations in Albania, Bulgaria, Côte d’Ivoire, Georgia, India, Kazakhstan, Kenya, Kyrgyzstan, Mauritius, Mongolia, Russian Federation, Rwanda, Serbia and Montenegro, South Africa, Togo, Turkey and Ukraine were among the many that raised the importance of greater harmonization and alignment.
The Brazzaville Commitment: The united voice of Africa on universal access

The Africa regional consultation on scaling up towards universal access, held in the Republic of the Congo on 8 March 2006 concluded with the “Brazzaville Commitment”: a document that expressed concern about “the disproportionate share and severe impact of the HIV and AIDS burden borne by Africa, especially by women and girls, and the limitations in our ability to match this epidemic in either its scale or complexity”.

The Brazzaville Commitment also makes the following:

- a call for innovative ways to mobilize resources for AIDS at the subregional level;
- a call to ensure the establishment of regional and national bulk purchasing, technology transfer, South-South collaboration and subregional production of AIDS-related drugs and commodities, including support in using TRIPS (WTO’s Agreement on Trade-Related Aspects of Intellectual Property Rights) flexibilities;
- a call for accelerated HIV and AIDS research in Africa, including traditional medicines, and the protection of Africa’s indigenous knowledge;
- a pledge to undertake to harmonize regulatory procedures for medicines and removing cross-border taxation on essential medicines and commodities;
- a request for States to align national budgets to national AIDS plans, including balanced allocation between prevention, treatment, care and support;
- a request for States to enhance training, retention and better use of Africa’s available human resources and making them responsive and accessible to all communities without sacrificing quality; and
- a pledge to undertake to promote and support an audit of legal instruments to verify harmonization of laws and policies with national AIDS goals on stigma, discrimination and gender issues.
Pakistan provides a good model for donor harmonization. The country consultation reported that development partners are jointly working within a “Donors HIV and AIDS Group”, and that multilateral and bilateral supporters developed their AIDS support strategies in close consultation with national authorities. The World Bank has aligned its activities with the country’s planning cycle, UN agencies are working through one platform, and bilateral programming and reporting is conducted in a harmonized fashion. The consultation stated that the next step will be for all donors to align their funding to the budget cycles of the national government.

However, it is clear that current efforts at country and global levels still require strengthening, especially concerning the participation of civil society. For example, the “Three Ones” principles have been formally adopted in India, but not put in practice. The country consultation reported that the presence of a variety of players with different objectives and lack of full conformity to the National Strategic Framework and annual activity plans. This has led to a lack of harmonization at national, state and implementation levels. India consultation participants called for stronger leadership by the National AIDS Control Organization—including a stronger coordination mandate—and improved alignment of stakeholders’ implementation plans and processes.

The regional consultation for Africa noted a lack of harmonization and alignment to national priorities and the imposition of spending ceilings and heavy conditions. In addition, donors allocate their funding between and within countries and across thematic areas in ways that do not match needs.

Based on the results of the consultations, UNAIDS called on the international community to ensure that no credible, costed, evidence-informed, inclusive and sustainable national AIDS plan should go unfunded. UNAIDS also recommended that AIDS funding needs be met through greater domestic and international spending, and that countries have access to predictable and long-term financial resources. Specific recommendations in the UNAIDS assessment included these.
National AIDS authorities and their partners, with full participation of all stakeholders, should develop or adapt prioritized and costed AIDS plans, which are aligned with national development plans, and which are ambitious but feasible in reaching their targets for moving towards universal access.

Once a credible and sustainable plan is in place, conditions on donor funding for national AIDS programmes should be reduced to those which relate to good governance, fiduciary safeguards and the effective use of these funds to achieve national objectives.

Governments should ensure that the impact of AIDS is included in the core indicators for measuring progress in implementing national development and poverty reduction plans.

Governments, where needed, should initiate a transparent and inclusive dialogue with all stakeholders to ensure fiscal space is created for AIDS spending as high-priority social expenditures.

National governments and international donors should significantly increase the financial resources available for AIDS by strengthening and fulfilling existing commitments, by fully supporting the Global Fund and by supporting other innovative financing mechanisms, for both public sector and nongovernmental providers of AIDS interventions.

International donors and partner countries should adhere to the “Three Ones” principles and implement the recommendations of the Global Task Team on Improving AIDS Coordination among Multilateral Institutions and International Donors for the efficient and effective use of financial resources, including through alignment to national priorities.
Scaling up access to HIV prevention, treatment, care and support: The next steps

People

Strengthening human resources and systems

The lack of trained professionals who can provide treatment and care presents a major constraint on health-care systems, particularly in low-income countries. More than 4 million additional doctors, nurses, midwives, managers and public health workers are urgently needed to avert serious crises in health-care delivery in 57 countries around the world—26 of these in sub-Saharan Africa\(^{12}\). In total, the World Health Organization (WHO) estimates that at least 1.3 billion people around the world lack access to even the most basic health care. This shortfall is negatively affecting the AIDS responses of many countries. There is insufficient availability and quality of pre- and post-test counselling, contact tracing and health education in Mongolia and Suriname, home care in Somalia, and diagnosis and treatment of opportunistic infections diagnosis in Armenia. Insufficient human resources was identified as a primary obstacle to the delivery of antiretroviral treatment and other HIV-related services at the country consultations in Albania, Armenia, Bangladesh, Barbados, Belize, Botswana, Bulgaria, Chad, Eritrea, Guyana, Kenya, Lao People’s Democratic Republic, Lesotho, Malawi, Mongolia, Nigeria, Papua New Guinea, Republic of Moldova, Senegal, Serbia, Sri Lanka and Sudan. The conclusions from the regional consultations in Africa, Asia, the Caribbean and the Commonwealth of Independent States reinforced the conclusions of country consultations. They recommended policy changes and new alternative delivery models to strengthen and protect existing human resources and to enable health, education and social systems to mount an effective AIDS response.
“Delivering essential services and achieving targets for universal access to HIV prevention, treatment, care and support depend vitally on a strong foundation of human resources. Developing innovative service delivery methods, scaling up to reach the most affected communities, promoting more supportive work environments to retain and motivate workers, and integrating HIV-related services into wider development services are key components of a successful strategy.”

Kemal Derviş, UNDP Administrator

As funding for AIDS increases, a challenge for many countries—especially high-prevalence, low-income countries—is how to increase absorptive capacity and mobilize sufficient human resources for a push towards universal access while also promoting sustainability, maintaining macroeconomic stability and fostering rapid growth. While recognizing the importance of maintaining macroeconomic stability and fostering rapid growth, Global Steering Committee members from low-income countries reported that excessively tight deficit-reduction and inflation-reduction targets are constraining the hiring and retention of the doctors, nurses, community health-care workers, teachers and administrators who are needed to scale up towards universal access. These fiscal constraints often contribute to the poor working environments and salary levels, making it extremely difficult for some countries to retain their personnel. In some places, remuneration levels were reported as close to or below subsistence level, causing the emigration of skilled professionals in record numbers to high-income countries and draining human capacity in the countries where it is most needed.

The Guyana, Lesotho, Mongolia, Rwanda, Serbia and Sudan consultations specifically identified the need to offer improved remuneration to retain skilled workers in the public sector. The Africa consultation, along with many Global Steering Committee members, called for a specific effort among international finance institutions, health and finance ministries, national AIDS authorities and civil society to adjust macroeconomic and fiscal frameworks to address the reality of AIDS.
Stronger links between AIDS programmes and wider health, education and social services can help address some of the human resource shortages, as well as integrating these into sexual and reproductive health programmes, mother and child health-care services and treatment services for tuberculosis and other opportunistic infections. The regional consultation in Africa stressed the importance of stronger links between AIDS services and wider health, education and social services. The Global Steering Committee called for an integrated approach through the development of broad “implementation partnerships” involving government (ministries of finance, health, education and local government, and public service commissions), representatives of civil society, faith-based organizations, professional associations and labour unions, and private sector employers, as well as flexible funding at district, local and community levels.

Many HIV treatment approaches remain highly dependent on scarce and expensive medical professionals and highly sophisticated laboratory equipment, which are in short supply in low-resource settings. Implementation of alternative, lower-cost human resource models for delivery of HIV prevention, treatment, care and support—including the deployment of auxiliary and community workers and engaging people living with HIV in service delivery—is urgently required. Where needed, governments should eliminate barriers that prevent community health-care workers and nurse practitioners from delivering antiretroviral therapy and assisting in patients’ adherence to treatment and care regimens, consistent with their level of qualifications.

Models of community prevention, care and service delivery programmes have been demonstrated in settings as diverse as Haiti, Malawi, South Africa and Thailand. Developed by civil society and faith-based organizations in collaboration with international nongovernmental organizations, these programmes first sensitize communities to develop a local commitment to controlling the spread of HIV. They build on local commitment to train volunteers for specific aspects of service provision, like prevention, home care and care for orphans and other vulnerable children. Several African countries are moving to provide remuneration to community volunteers in order to sustain their commitment and recognize their contributions. Médecins Sans Frontières and Partners in Health are among many
Brazil: pioneers in universal access to treatment

Epidemics in Latin America tend to be highly concentrated among groups at particular risk, especially injecting drug users and men who have sex with men. In some cities, infection levels above 60% prevail among injecting drug users, many of whom use unclean injection equipment. Brazil already had 620,000 adults and children living with HIV at the end of 2005, 220,000 of them female\textsuperscript{13}. In the early 1990s, Brazil adopted a universal access approach to treatment as a basic human right, reducing mortality and improving quality of life for people living with HIV. Treatment coverage in Brazil now exceeds 80%\textsuperscript{14}.

“Although we have come far, there are still gaps, mainly regarding prevention activities”, says Dr. Mariangela Galvao Simão, Director of the National AIDS Programme. “Our prevention strategy is quite comprehensive—the idea is to maintain a ‘virtuous circle.’ We can scale up prevention activities, decreasing stigma related to the disease, and avoiding new infections or diagnosing early infections, which in turn will lead to early treatment and so on… . The underlying issues regarding the fight against AIDS are so interrelated, that there is no effective response if you do not have a balanced approach.”

Based on the results of the consultations, UNAIDS called on the international community to adopt large-scale measures to strengthen human resources to provide HIV prevention, treatment, care and support and to enable health, education and social systems to mount an effective AIDS response. Specific recommendations in the UNAIDS assessment included these.

- Countries should adopt, where needed, alternative and simplified delivery models to strengthen the community-level provision of HIV prevention, treatment, care and support, including measures to enable the shifting of tasks such as the prescribing of drugs, HIV testing and counselling, and behaviour change communication to nurses, educators and community workers, including people living with HIV.

\textsuperscript{13} UNAIDS (2006a).
\textsuperscript{14} UNAIDS (2005).
Dr. Simão attributes Brazil’s success on treatment to principles promoting an inclusive, strong national authority with a broad spectrum of civil society participation on the decision-making levels; and one strategic framework, discussed and agreed upon with all partners, including political partners. This type of structure is in line with the “Three Ones” principles advocated by UNAIDS as a means to ensure a more efficient and coordinated national AIDS response. In addition, Brazil has a structured, functional national health system, and health is a recognized right of every citizen. Civil society is also involved in the planning, management and implementation of the AIDS response.

In 2001, the Brazilian Cooperation Agency, the official government agency responsible for technical cooperation, made history in South-South cooperation in HIV and reproductive health by establishing a partnership with the United Nations to transfer its experience to Portuguese-speaking African countries. It also works with Central and South American countries, including Bolivia, Colombia, the Dominican Republic, El Salvador, and Paraguay to help them procure antiretroviral drugs worth US$ 1 million to support pilot treatment projects.

- National governments and international donors should take measures, where needed, to retain and motivate health workers, educators and community workers, including through better wages, housing, benefits and safe and secure working conditions.

- National governments and international donors should increase financing for training and accreditation centres in countries facing severe human resource shortages.

- National governments should greatly expand their capacity to deliver comprehensive AIDS programmes in ways that strengthen existing health and social systems, including by integrating AIDS interventions into programmes for primary health care, mother and child health, sexual and reproductive health, tuberculosis, nutrition, orphans and vulnerable children, as well as formal and informal education.
Affordable medicines, diagnostics and prevention commodities

Inadequate supply of medicines, HIV testing kits and other vital commodities, such as male and female condoms, is impeding scale up of treatment, care and prevention programmes. This obstacle is in part due to the costs of these commodities, and in part due to the difficulties low- and middle-income countries face as they procure and distribute these life-saving goods.

The price of first-line antiretroviral drugs has plummeted in the last five years. However, increasing numbers of people on HIV treatment require second- and third-line combinations of these medicines. Additionally, few simple and palatable antiretroviral drugs are available in countries to treat the increasing number of children with HIV. The prices of these newer medicines and some viral monitoring equipment are still high in many parts of the world. Moreover, countries with similar income levels are paying very different prices for the same product. At the Asia-Pacific regional consultation, participants noted that 21 countries in the region pay 21 different prices for the same medicine. Although the Global Steering Committee noted the importance of differential pricing, the Asia-Pacific and Latin America consultations expressed concern that countries in their regions are unable to procure patented HIV medicines at differential prices proportionate to their income levels.
National and regional consultations from Latin America to Africa to Asia-Pacific called for measures to support countries to use the flexibilities in global trade rules, such as the option of compulsory licensing provided by the World Trade Organization (WTO) Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS), to enhance access to more affordable generic HIV medicines. In recent years, some low- and middle-income countries have opted for more extensive patent protection than required under the multilateral WTO intellectual property rules. Many Global Steering Committee members and the Latin America consultation called for a programme to support countries’ efforts to utilize the flexibilities in the WTO multilateral rules. The Africa consultation called upon regional economic entities to support countries in using the TRIPS flexibilities, and both this consultation and the Asia–Pacific consultation called for the establishment of regional mechanisms for price negotiations and procurement.

Shortages in commodities also arise from problems in supply chain management and lack of competent procurement personnel. Albania cited procurement and planning weaknesses as a fundamental issue obstructing the delivery of affordable commodities. With no system for determining and tracking needs, usage rate and proper planning for these needs, year long planning is impossible, and drugs often pass their expiry date or supplies are otherwise exhausted well before the next delivery. The same is true for condoms, highlighting a need for improved monitoring systems for forecasting supply needs.

“We cannot just focus on treatment or health systems. We are forgetting a whole range of social systems whose actions drive the epidemic. Yes, we will make progress in terms of abolition of user fees. But what’s that if you have to find transport to travel 300 kilometres for a proper virological assessment? What does it mean that you don’t pay $2 if you need $15 to get there? How free is free access, especially if you are a woman and have no control over resources?”

Elizabeth Mataka, Director of Zambian National AIDS Network and member of the Global Steering Committee
The consultations in Botswana and Sierra Leone—raising a point echoed by Elizabeth Mataka—identified a lack of adequate transport as a key factor in distribution, while Nigeria noted a lack of detailed information on service delivery points throughout the country, making it difficult to identify weaknesses in the supply chain. Many countries, such as Azerbaijan and Papua New Guinea also called for regional procurement mechanisms to facilitate the delivery of low cost drugs as well as a more decentralized health-care delivery system.

HIV-related commodities are subject to taxes and tariffs in many countries, increasing their prices. Efforts to eliminate these taxes and tariffs as soon as possible were widely urged throughout all levels of the consultative process. Reports from a number of national consultations showed that increasing numbers of countries are also seeking local production capacity for HIV medicines. However, lack of sufficient technology transfer and overall financial viability were cited as obstacles. Local production requires a careful analysis of trade-offs, including whether small local suppliers serving small markets will have the scale and market size to ensure quality and minimize overhead costs as larger companies (in India and South Africa, for example) are able to do.

National laws may create barriers in access to effective HIV prevention programmes and commodities, such as harm reduction measures for injecting drug users. Regional consultations in Asia and the Pacific, the Commonwealth of Independent States, Latin America, and the Middle East and North Africa all called attention to the importance of addressing barriers in access to evidence-informed prevention interventions. Country consultations in Kazakhstan, Mauritius, the Republic of Moldova, the Russian Federation and elsewhere reported legal barriers to the distribution of HIV-related commodities.

Based on the results of the consultations, UNAIDS called on the international community to remove major barriers—in pricing, tariffs and trade, regulatory policy, and research and development—to speed up access to affordable quality HIV prevention commodities, medicines and diagnostics. Specific recommendations in the UNAIDS assessment included these.
Scaling up access to HIV prevention, treatment, care and support: The next steps

- National governments where needed should remove legal, regulatory or other barriers that block access to effective HIV prevention interventions and commodities such as condoms, harm reduction and other prevention measures.

- UNFPA, UNICEF and WHO—in collaboration with existing global and regional procurement facilities, and by promoting informed demand forecasting and bulk procurement, differential pricing and where appropriate voluntary licencing—should help lower prices for HIV prevention and treatment commodities, including second- and third-line antiretrovirals.

- Countries where needed should reform their legislation and tax codes to exempt HIV prevention and treatment commodities, including HIV medicines, from all taxes and tariffs.

- National governments, with support from international partners and multilateral organizations, should employ where needed the flexibilities in the World Trade Organization’s Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) to secure access to a sustainable supply of affordable HIV medicines and essential health technologies, including through local production where feasible.

- Countries should reform their legislation and regulations, as necessary, to allow WHO prequalified medicines, or medicines approved by other widely recognized stringent drug regulatory bodies, to obtain provisional marketing approval to allow access to life-saving HIV medicines and diagnostics prior to full registration by national drug regulatory authorities.

- Pharmaceutical companies, international donors, multilateral organizations and other partners should develop public-private partnerships to promote quicker development of paediatric antiretroviral formulations and other medicines, and new HIV-related pharmaceutical products (HIV vaccines, microbicides).
Civil society and people living with HIV

“We made the government realize that to do community mobilization around treatment, you need us, people with AIDS to talk to people, to help them with disclosure and treatment compliance,” says Ugandan treatment activist Lydia Mungherere.

A physician active in lobbying lawmakers and government officials as part of the National Forum of Networks of People Living with HIV/AIDS in Uganda, Mungherere nearly died of AIDS in 1999. Antiretroviral treatment gave her a new life and a new role in making government more responsive to the needs of people living with HIV.

The National Forum, which she helped found in 2004 along with Lillian Mworeko, works in full partnership with the Ministry of Health to widen access, develop treatment literacy and ensure patient adherence. In many other countries however, governments are distinctly less open to civil society input, despite the fact that 42 governments formally agreed to principles for the Greater Involvement of People Living with AIDS (GIPA) in the declaration of the 1994 Paris AIDS Summit.

Because they come from outside established bureaucracies, national and international nongovernmental organizations can often draw attention to issues that may be difficult for governments in poor countries to raise themselves. They are subject to fewer political constraints and are closer to the interests of their clients. Consequently, they have become increasingly involved in providing antiretroviral treatment, serving as extensions of under-resourced health and social service systems in providing prevention, treatment, care and support for families and children living with HIV. They are also critical in campaigns for scaling up because they can identify people living with HIV, support them to seek treatment, and ensure compliance. The Treatment Action Campaign and the Asia-Pacific Council of AIDS Service Organizations (APCASO) are both good examples of the impact civil society can have in making a real difference to those living with

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HIV. ActionAid, the Global AIDS Alliance, the Student Global AIDS Campaign, and RESULTS Educational Fund have challenged national and international fiscal policies that restrict public expenditure and sometimes work against the strengthening of national systems, including in the health sector\(^\text{16}\).

**Regional civil society networks play an important role in regional consultations**

Regional networks were key to the success and inclusiveness of the universal access regional consultations because they are ”in the loop” on regional activities and were able to act quickly to ensure civil society involvement and preparation, according to Susan Chong, Coordinator of the Asia-Pacific Council of AIDS Service Organizations (APCASO). Chong, who was a Global Steering Committee member and participated in the Asia-Pacific regional consultation, noted that regional civil society networks are able to raise sensitive issues which country civil society representatives may be too intimidated to discuss in the presence of officials from their governments.

Physician activists groups were the first to demonstrate that antiretrovirals could be delivered in resource-poor settings. Médecins Sans Frontières (Doctors Without Borders) pioneered low-cost antiretroviral treatment delivery in Cameroon in 1998, while Partners in Health modelled community-based service delivery in Haiti in 1998, a model now being replicated elsewhere.

*Faith-based organizations come to the fore*

In Africa, faith-based organizations have contributed to reaching communities with prevention, care, support and treatment, also giving them a significant role as the providers of upwards of 40% of all health care.

Faith-based organizations “have the capacity to do education at the grassroots level and advocacy in the corridors of global power, and can bring strong moral influence

\(^{16}\) Rowden R et al. (2004).
towards the elimination of stigma and discrimination,” says Rev. Robert Vitillo of CARITAS.

The opinions of the leaders of faith-based organizations are also critical. When Rev. Benjamin Nzimbi, Archbishop of the Anglican Church of Kenya, publicly apologized in March 2006 to people living with HIV regarding a previous statement by his church that AIDS is “a disease for sinners and a curse from God,” many important people got the message.

Given their global reach, faith-based organizations around the world have been rallying to the call to reverse the spread of HIV. Under the Sangha Metta project in Thailand, Buddhist monks teach villagers how to avoid high-risk behaviour, help set up support groups, provide counselling, train people with HIV in handicrafts and take care of children orphaned by AIDS.

“During the Global Steering Committee meetings, some members stated that governments had to make “hard choices”—i.e. about whether or not antiretroviral medications should be provided to their citizens or young girls should receive education. I maintain that these are not the choices to be made—that both treatment and education are possible in the present day world, and that, to the contrary, choices need to be made about whether or not to wage war and continue massive destruction of human life, and about how much profit is necessary in commercial endeavours that have deep impact on the health and welfare of the human family.”

Rev. Robert Vitillo, CARITAS Internationalis and member of the Global Steering Committee
In several regions and countries around the world, inter-faith organizations have been set up, such as the African Network of Religious Leaders Living With or Personally Affected by HIV/AIDS. At country level, a number of different initiatives have also been introduced. Imams in Kyrgyzstan have teamed up with UNDP to participate in awareness-raising workshops on HIV and AIDS. Following these sessions, where they meet with nongovernmental organization representatives and government officials, the imams then convey the information within their communities, translating the message through Islamic teachings. There is still reticence from some quarters, but many young people are deeply impressed at this move towards breaking the taboos surrounding sexuality and drug use, in a way that is meaningful to them\(^\text{17}\).

More recently in Yemen, UNDP supported representatives of sheikhs to attend training on the role of religious leaders in the AIDS response in November 2005. Following the training, the sheikhs have set up a network with fellow religious leaders to promote faith-based sensitization to HIV during weekly mosque gatherings\(^\text{18}\).

**The business response**

Businesses are making strong progress in partnering with governments, multilateral organizations and communities to support the global response to AIDS. As AIDS continues to have a devastating impact around the world, businesses are responding to the pandemic by adopting multifaceted strategies to confront the disease in the workplace and community, by partnering and raising awareness. The Global Business Coalition on HIV/AIDS—a partnership regrouping over 200 international companies worldwide—has been facilitating a strong and systematic response to tackling HIV, and a recent study demonstrates that the private sector is moving towards universal access. As Executive Director of the Coalition Richard Holbrooke notes, “The study shows that developing and implementing an effective HIV/AIDS program takes time and commitment, however in five years of committing to HIV/AIDS, companies surveyed have more than doubled their HIV/AIDS activities.”\(^\text{19}\)

\(^{17}\) IRIN News (2004).
\(^{18}\) Reliefweb (2006).
The next steps: Target-setting and strengthening accountability

Progress in the AIDS response has been more significant in the past five years than over the previous 20 years. A steadily growing number of African countries are seeing a sharp fall in new HIV infections, and, beyond the oft-cited examples of Thailand and Uganda, prevalence rates are in decline in other countries such as Kenya, Zambia, Zimbabwe, some areas of Haiti and Burkina Faso. Even these countries, however, cannot afford to slow their pace. HIV infections could easily rise if behaviour change does not increase, especially among young people. As more people become infected, it will become more difficult for public health systems to systematically treat people living with HIV. Universal access is about building on the current momentum in a comprehensive way. The country consultations and the 2006 High Level Meeting on AIDS reiterated the need for governments to work together with civil society, and for all partners to align their resources and energies behind national priorities set in an inclusive and transparent manner.

Thailand sets more ambitious targets

In its universal access consultative process, partners in Thailand set even more ambitious targets for 2010 than the country originally had in its sights. This welcome move follows signs of a resurgence of HIV after many years of progress.

Thailand has successfully reduced new infections from a peak of 140000 in 1991 to 21 000 in 2003 because of marked behaviour change in men, including increased condom use and reduced patronization of brothel-based sex workers. Now, with the majority of new infections now occurring in spouses (see Figure pg. 43), Thai public health authorities are learning that they must continually monitor sexual and other infection-related behaviour, and adjust programmes accordingly.
With 570,000 adults and children living with HIV, Thailand has accelerated access to treatment by integrating treatment and prevention of mother-to-child transmission through its primary health care and hospital system. Thailand has also redoubled prevention efforts, particularly among men who have sex with men and injecting drug users, committing on 6 February 2006 to cut anticipated new infections to 6000 in 2010, down from the current estimate of 17,000 new infections annually.

There is also wide agreement that improved accountability mechanisms are crucial to motivate, sustain, measure and publicly report progress towards universal access. Setting ambitious but feasible national targets for 2010, with specific and bold intermediate targets for 2008, is essential for countries to prioritize their efforts, mobilize resources and monitor and evaluate their results. To ensure national targets are both ambitious and feasible, and are accepted by all stakeholders at country level, UNAIDS has made a clear recommendation for national AIDS authorities to ensure target-setting is transparent and inclusive, especially regarding the participation of civil society, people living with HIV and people in most-at-risk populations. UNAIDS

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**Estimated number of new HIV infections in Thailand by year and changing mode of transmission**

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<tr>
<th>Year</th>
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<td>1986</td>
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<td>2002</td>
<td>360,000</td>
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Spouse: heterosexual transmission of HIV in cohabiting partnerships; SW: HIV transmission through sex work; IDU: HIV transmission through injecting drug use; MTCT: mother-to-child transmission of HIV

UNAIDS has also called for regular participatory reviews of national AIDS responses, as well as transparent and inclusive public financial management and expenditure tracking to verify the allocation, use and impact of AIDS funding.

The Political Declaration of the 2006 High Level Meeting on AIDS commits Member States to set these targets by the end of 2006, to also maintain sound and rigorous monitoring and evaluation frameworks and to regularly report on progress towards their targets. It also requests that UNAIDS provide a set of standard indicators and guidance for this target-setting process, and to assist national and regional efforts to monitor and report on efforts to achieve these targets.

What is UNAIDS?

The Joint United Nations Programme on HIV/AIDS, or UNAIDS, brings together the efforts and resources of ten UN system organizations in the response to AIDS. These ten Cosponsors are: the Office of the United Nations High Commissioner for Refugees, the United Nations Children’s Fund, the World Food Programme, the United Nations Development Programme, the United Nations Population Fund, the United Nations Office on Drugs and Crime, the International Labour Organization, the United Nations Educational, Scientific and Cultural Organization, the World Health Organization and the World Bank.

Intensified global action against AIDS requires intensified support from UNAIDS. Less than three weeks after the 2006 High Level Meeting, the governing board of UNAIDS—known as the Programme Coordinating Board—met to discuss how the United Nations system will support countries’ efforts to fulfil the commitments made in the Political Declaration. The Board reiterated the Political Declaration’s call for UNAIDS to support countries as they set targets and monitor progress towards their achievement. The Board also requested that UNAIDS facilitate full, active and meaningful civil society participation in target-setting and monitoring and reporting on progress, and to intensify social mobilization for the broadening of national AIDS responses to ensure they reach the community level.
Additional Board decisions related to universal access included requests for UNAIDS to:

- strengthen its assistance to the coordination of national AIDS programmes, as elaborated in the “Three Ones” principles, including the development of a scorecard-style accountability tool and support to national assessments of partner alignment;

- facilitate the building of costed national plans;

- improve its methodology for global resource needs estimates;

- assist in the mobilization of new and additional resources from donor countries and from national budgets and other national sources, as well as strengthening existing financial mechanisms and continuing development of innovative sources of additional funds;

- conduct a gender assessment of three to five national AIDS plans and develop policy guidelines to address gender issues in a practical way;

- cooperate with initiatives based on innovative financing mechanisms, including the International Drug Purchase Facility/UNITAID, that aim to contribute to universal access on a sustainable and predictable basis;

- analyze the potential impact of and implementation issues relating to a proposed International HIV Testing Day; and

- develop a four-year framework for UNAIDS support to countries’ efforts to implement fully the 2001 Declaration of Commitment on HIV/AIDS and the 2006 Political Declaration on HIV/AIDS, including proposals on how to help enable developing countries to employ the flexibilities outlined in the World Trade Organization’s Agreement on Trade-Related Aspects of Intellectual Property Rights and to strengthen their capacities for this purpose.

The road to universal access is an arduous one, and will demand a prolonged investment of money, time and political will by all partners in all countries and regions. The day when AIDS is confined solely to history books may be a long way off, but the efforts made in recent months marked a significant step towards an end to AIDS. The challenge remains to convert our new commitments into action.

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20 UNAIDS (2006b).


This booklet tells the story of the men and women who have been working towards universal access, whether in consultations in their countries, regions or globally, or through their dedicated activities in government, the private sector, journalism, activism and all forms of service within the AIDS response. It explains the necessity for universal access, which encompasses within it all previous initiatives, but goes a step further by daring to dream that one day, all those who need it will have access to HIV prevention, treatment, care and support. It reviews the political process around universal access, in countries, regions and globally, and it outlines the path that countries will have to forge for themselves, with the help of regional and international partners, in pursuit of this goal.