

## Unit 3 – Global Responses to HIV/AIDS

### Learning Objectives:

#### How can international declarations and initiatives be used to fight HIV/AIDS?

After studying this unit you should be able to:

- Have knowledge of the key international and regional declarations on HIV/AIDS and some of the relevant commitments made by the signatory governments;
- Be familiar with some important international implementation strategies including the ABC Approach, the “Three Ones,” the “3 by 5” and Universal Access initiatives.
- Have knowledge of some of the key international funding initiatives to address HIV/AIDS; and
- Be aware of some of the international parliamentary initiatives developed to address HIV/AIDS.

### Introduction

The presence of HIV/AIDS is expansive, and the global community has been forced to address the pandemic on a larger scale than ever. As challenges are overcome and new challenges emerge, global responses are also evolving. Organizations such as the United Nations and the World Health Organization have been instrumental in addressing the complexity of needs with regards to this issue, by developing countless documents and recommendations for effective HIV/AIDS mitigation around the world. Although regional and national responses may vary, success can be connected to the extent to which global frameworks are considered and integrated within country policies.

Unit 3 gives an introduction to some key international and regional declarations and frameworks that have been developed to address the HIV/AIDS crisis. It also provides some information on the progress made to demonstrate where responses can be improved, but to also show the importance of international frameworks in garnering

national success. It also presents three of the key international funding initiatives, as well as some prominent parliamentary initiatives to address HIV/AIDS.

## **International Declarations and Commitments on HIV/AIDS**

### **The United Nations Millennium Declaration (2000)**

In September 2000, world leaders came together in New York for the Millennium Summit to discuss the role of the United Nations at the turn of the century. At this

#### **Box 1**

##### **The Millennium Development Goals**

1. Eradicate extreme poverty and hunger
2. Achieve universal primary education
3. Promote gender inequality and empower women
4. Reduce child mortality
5. Improve maternal health
6. Combat HIV/AIDS, malaria, and other diseases
7. Ensure environmental sustainability
8. Develop and global partnership for development

Source: [www.un.org/millenniumgoals](http://www.un.org/millenniumgoals)

meeting, the United Nations Millennium Declaration was adopted by 189 nations, which committed their nations to a new global partnership to reduce extreme poverty and set out a series of time-bound targets to reach this goal by the year 2015. Deriving from the Declaration was a framework for progress, outlined in the Millennium Development Goals (MDGs). The objective of the MDGs is to produce meaningful and achievable development targets aimed at reducing

poverty, improving access to education and health care, especially for women and girls; halting and reversing the spread of pandemic diseases such as HIV/AIDS, malaria and tuberculosis; as well as developing, strengthening, and maintaining partnerships for development, including debt relief and development assistance. The MDGs are also strongly linked to human rights - the rights of each person on the planet to health, education, shelter, and security.

The international framework for these eight goals has 18 targets as well as 48 technical indicators to enable measuring progress. Since their adoption by countries worldwide, the MDGs **"have become a universal framework for development and a means**

***for developing countries and their development partners to work together in pursuit of a shared future for all”(UN, 2007).***

It has been noted that in order for the progress to be achieved by the 2015 deadline, nationally developed strategies and budgets must genuinely reflect the MDGs, and be backed by adequate funding and accountability.

### ***Progress of the MDGs***

The Millennium Development Goals Report 2007 indicates that the global achievements as of 2007, the midpoint between 2000 and 2015, have been varied. Results have shown some optimistic gains towards the MDGs in regions where the challenges are the greatest and the potential for continued success is strong. This demonstrates the unprecedented commitment by developing countries and their partners to meet the MDGs.

### ***MDG Successes***

According to the UN Millennium Development Goals Report 2007 there are several areas where success has been achieved:

- The numbers of extreme poor in sub-Saharan Africa has stabilized. Nevertheless, the region is still not on track to meet the goal of halving extreme poverty by 2015;
- Progress has been made in primary school enrolment, growing to 88% universal enrolment in 2005;
- Women’s political participation has increased, although slowly, with more and more women holding seats in parliament;
- Child mortality has declined, and more children are receiving preventative treatments for diseases such as measles;
- Malaria interventions have expanded, and tuberculosis appears to be on the decline.

However, other country and regional examples have shown that without firm political leadership many millions of people will not see the promise of the MDGs positively affect

their lives. All stakeholders need to devote additional action and sustain this until 2015 in order to fulfill their commitment to the MDGs.

Despite the progress made, much remains to be done. According to the 2007 Millennium Development Goals Report, the shortfalls are the greatest in sub-Saharan Africa but many of the regions face challenges with regards to lack of employment opportunities for young people, gender inequalities, rapid and unplanned urbanization, deforestation, increasing water scarcity and high HIV prevalence. Insecurity and conflict, lack of technical expertise, support, and funding can also undermine achieving the MDGs.

### ***MDG Challenges***

According to the same report, some of the key challenges and areas for improvement are:

- **Maternal health** Over half a million women continue to die each year from treatable or preventable health complications during pregnancy and childbirth;
- **Gender inequality** Women continue to be disadvantaged. Aside from agriculture, in sub-Saharan Africa less than one third of women earned a salary in 2005;
- **Child health** Progress to reduce malnutrition among children continues to be slow primarily in regions such as Southern Asia and sub-Saharan Africa. For example, children under the age of five who are underweight has only declined marginally from 33% to 29% in sub-Saharan Africa;
- **School enrolment** Although there has been some improvement, sub-Saharan Africa has only seen 70% of children enrolled in schools as of 2007;
- **Sanitation** Half of the world's population lack access to basic sanitation;
- **Unequal economic growth** The benefits from economic growth in developing countries are not shared equally among the world's nations, particularly in Eastern Asia, resulting in widened income inequality and decreasing consumption among the poorest;
- **Unemployment** Employment opportunities, primarily among young people, remain low, as they are more than three times likely to be unemployed than adults;

- **The number of people dying of AIDS** This number continues to increase worldwide, and prevention measures are failing to keep up with rates of new infection. In 2005, more than 15 million children had lost one or both parents to AIDS.

It has been demonstrated that it is possible to achieve rapid and large-scale progress towards the MDGs if there is a strong political leadership and the government develops policies and strategies that targets the needs of the poor in an effective way and combine them with adequate financial and technical support, both domestically and from the international community. For example, with support from the UN, 41 countries in sub-Saharan Africa had, as of 2007, moved towards preparing national development strategies that are aligned with the MDGs and other development goals agreed upon through the UN.

### ***The MDGs and HIV/AIDS***

Although only Goal 6 - Combat HIV/AIDS, malaria, and other diseases – focuses on HIV/AIDS directly, all the MDGs are important to HIV/AIDS mitigation as they both explicitly and implicitly challenge structures which leave people vulnerable to HIV. For example, it is believed that:

- The eradication of poverty and hunger will prevent individuals, namely women, from engaging in high-risk survival strategies such as sex work which inevitably increases risk to HIV infection.
- Poverty reduction also limits rates of migration and labor seeking opportunities, which protects migrant laborers from vulnerability and exposure.
- Proper nutrition also slows the progress of HIV to the AIDS stage among those who have already been infected.
- The provision of education also has obvious consequences, as it allows young people the opportunity to learn and understand HIV prevention strategies at an earlier age.
- The promotion of gender equality will provide vulnerable groups such as women and girls, and men who have sex with men equal grounds to negotiate safer sex within the home, and ability to access HIV education and treatment facilities within their communities.

- The reduction of child mortality, specific to pediatric HIV patients, will provide children with the life saving medications they need to develop and grow to their full potential, similarly maternal health will prevent the spread of HIV to children in the first place, and reduce the number of orphans by keeping mothers alive.

The importance of applying the MDGs to HIV mitigation strategies are clear, yet without timely commitment and reliable funding, it will be difficult to achieve such targets.

### ***Parliamentarians and the MDGs***

Parliamentarians can use the MDGs as a benchmark to hold their governments accountable. More precisely, parliamentarians have an important role to play in assuring that the MDGs are taken into account when national development strategies are being developed or updated. The MDGs should also be used as a guideline for policy development. During the budget process, parliamentarians have a responsibility to assure that there is a clear link between the MDGs and how they have been translated into the national development strategies and that sufficient funding is allocated to achieve the goals set out.

### ***United Nations General Assembly Special Session (UNGASS) Declaration of Commitment on HIV/AIDS (2001)***

In June 2001, heads of state and representatives of governments from all over the world met at the United Nations for the first General Assembly Special Session on HIV/AIDS. This meeting was a major milestone in HIV/AIDS responses, recognizing that HIV/AIDS is a serious threat to the achievements of global development goals, needing urgent action and a global commitment to enhance coordination and intensify the national, regional, and international efforts to strengthen capacity to effectively combat HIV/AIDS. The involvement of people living with HIV/AIDS, other vulnerable groups and civil society in the design, planning, implementation and evaluation of HIV programs was particularly emphasized. The meeting also stressed that with political will and financial resources the epidemic could be overcome, underlining the slogan of the meeting "*Global Crisis – Global Action*". At this meeting, political representatives issued a *Declaration of Commitment on HIV/AIDS*.

Although the Declaration is not a legally binding document, by signing the Declaration, heads of state and government representatives have committed to a number of key areas, which are clearly detailed. Success of the commitments is bound by measurable, timely commitments. In total there are 103 commitments contained within the Declaration. It can serve as a powerful tool that can help guide action, commitment, support and resources for the AIDS response, both within and outside of government. It is based on the principles of human rights, gender equity, as well as the recognition of factors that increase vulnerability to HIV.

*"In the war against HIV/AIDS, there is no us and them, no developed and developing countries, no rich and poor - only a common enemy that knows no frontiers and threatens all peoples. But we must all remember that while HIV/AIDS affects both rich and poor, the poor are much more vulnerable to infection, and much less able to cope with the disease once infected. The leadership and commitment shown in this Declaration will give new strength and inspiration to the thousands of health-care workers, teachers and community leaders fighting this disease in the poorest parts of the world, and to the millions suffering from its effects."*

**Source: Former UN Secretary-General Kofi Annan of the Declaration of Commitment on HIV/AIDS, UN**

Through the *Declaration of Commitment on HIV/AIDS*, global leaders recognize that:

- Prevention, care, support and treatment are mutually reinforcing elements and that must be integrated into a comprehensive response;
- Special attention needs to be given to address gender inequalities and vulnerable groups;
- Access to medication needs to be increased and human resources, health and social structures strengthened;
- Stigma, silence, discrimination and denial, as well as lack of confidentiality will undermine HIV; and
- HIV/AIDS needs to be addressed from a multisectoral perspective and taken in consideration in poverty eradication strategies and development policies.

### **Political Declaration on HIV/AIDS (2006)**

In 2006 the second High Level Meeting on AIDS took place at the United Nations. This was a follow-up meeting to discuss the outcomes from the implementation of the

*Declaration of Commitment on HIV/AIDS*. The meeting involved all sectors of the international community, governments, civil society and the private sector, with unprecedented opportunities provided for civil society organizations to take part in the meeting. For example, it was the first time a person living with HIV addressed the General Assembly plenary, which is normally reserved for Member States and UN officials. There was also a civil society hearing, which provided civil society an opportunity to exchange views with Member States.

The main focus of the *Political Declaration on HIV/AIDS* meeting of 2006 was to:

- Review progress on the 2001 *Declaration of Commitment on HIV/AIDS*, focusing on both constraints and opportunities for full implementation;
- Consider recommendations on how the targets set in the Declaration may be reached;
- Renew political commitment.

The meeting culminated in the adoption of the *Political Declaration on HIV/AIDS*, which aims at reaffirming and expressing recommitment to the full implementation of the *Declaration of Commitment on HIV/AIDS* in the coming years. Important to this document is the emphasis given to legal and trade barriers, which block access to treatment. As such, heads of state and their governments agreed to set national targets that reflected their commitment to **universal access to comprehensive treatment, care and support by 2010**.

Despite the ambitious goals set, the Political Declaration remains largely unrealized. At the end of 2006, only 90 countries had provided a target date and a strategic plan for achieving universal access to treatment. Furthermore, many countries continue to overlook key demographics, particularly children, women, and youth in their national plans. The *Political Declaration on HIV/AIDS* has also been criticized by African NGOs for not including the targets and commitments made in Abuja (see below), which lists targets, milestones and commitments which African states should meet to achieve universal access to prevention, treatment, care and support of HIV and AIDS by the year 2010.

## ***Progress on the Declaration of Commitment on HIV/AIDS and Political Declaration on HIV/AIDS***

By adopting the *Declaration on Commitment on HIV/AIDS*, member states committed themselves to monitor and regularly report on progress to the General Assembly and it was stressed that these national periodic reviews required the participation of civil society, people living with HIV/AIDS, vulnerable groups and caregivers to achieve progress, and ensure results are widely disseminated. UNAIDS co-sponsors and development partners with the UNAIDS Secretariat developed a set of core indicators for the monitoring of the *Declaration of Commitment* in close collaboration with national governments. These indicators were designed to help countries assess the current state of their national response while simultaneously contributing to a better understanding of the global response to the AIDS pandemic, including progress towards meeting the targets in the *Declaration of Commitment on HIV/AIDS*. The first round of reporting took place in 2003, and then in 2005, prior to the second high level meeting. At the beginning of 2008, *Country Progress Reports* from 147 countries were submitted to UNAIDS, which together represent the most comprehensive body of evidence ever assembled regarding the response to HIV in low, middle and high-income countries.

These reports have revealed gains in the response to HIV/AIDS in many regions, demonstrating a positive return on initial investment. These achievements provide a sense of optimism for the continuing work to be done.

Several **encouraging findings** from the 2008 reports include:

- **Youth Knowledge** Young people's knowledge of HIV has increased. In 2007, 40% of young males and 36% of young females had accurate knowledge of HIV. However this is still below the 95% commitment made in 2001;
- **ARVs in Pregnancy** The percentage of HIV-infected pregnant women receiving ARVs to prevent mother-to-child transmission has increased from 14% in 2005, to 34% in 2007;
- **Equal Access** More than 80% of countries, including 85% in sub-Saharan Africa have policies in place to ensure equal access among women to HIV prevention, treatment, care and support;

- **ARV Coverage** rose by 42% in 2007, reaching 3 million people in low- to middle-income countries, approximately 30% of those in need;
- **Assistance** According to recent household surveys, in 11 high prevalence countries an estimated 15% of orphans live in a household which received some form of assistance. A small increase from 10% in 2005;
- **Legal Coverage** The number of countries with laws in place to protect people living with HIV from discrimination has increased since 2003. One third of countries still lack legal forms of protection;
- **Funding** for HIV-related activities reached USD \$10 billion in 2007. This is a 12% increase from 2006, and a ten fold increase in the last decade.

Despite this progress, there is still a pressing need for a stronger commitment to HIV prevention, as in 2007 the number of new HIV infection was 2.5 times higher than the increase in the number of people receiving ARVs.

The progress reports provided important input for the **Third High Level Meeting on AIDS**, which took place in June, 2008. The meeting was attended by government representatives from UN member states, as well as representatives from civil society and UN agencies. Discussions focused on the progress made, challenges remaining and sustainable ways to overcome them. The need for greater accountability, particularly in relation to funds spent by all stakeholders, and the need to adapt HIV prevention programming to local contexts was stressed. Moreover, the lack of effective programming directed to populations which are especially vulnerable to the disease, including sex workers, men who have sex with men, transgender populations and injecting drug users, in addition to the continued criminalization of related behaviors were some of the challenges highlighted by countries and civil society. The role of the Joint United Nations Programme on HIV/AIDS (UNAIDS) in the response was again recognized by countries as a critical element, in particular to ensure that national efforts are coordinated and complementary for progress towards the universal access goals by 2010 to move forward. Participants also recognized that HIV/AIDS is a public health- and a development issue which needs a multisectoral response. Human rights and

gender issues were singled out as imperative to an effective response and leadership and political accountability were underlined as the most important part of the solution.

### ***Parliamentarians and the Declaration of Commitment on HIV/AIDS and Political Declaration on HIV/AIDS***

These declarations are important tools for parliamentarians, as they contain clearly defined goals and commitments on how to address the HIV/AIDS pandemic from a national and global policy perspective. In addition, the progress reports can help highlight the strengths and weaknesses of responses at the national level.

Parliamentarians should make it their responsibility to review and provide input in the finalization of such reports, and should also encourage their governments to prepare reports by including all stakeholders in this process.

The Declarations and the results from the progress reports can also be used by parliamentarians to advocate for scaling up their response to HIV/AIDS and ultimately to holding their respective governments accountable to the commitments made through the Declarations.

### ***World Summit Outcome Document (2005)***

The *World Summit Outcome Document* was created in 2005, in which Heads of State and Government to the values and principles of the United Nations, and the *Charter of Rights and Freedoms* as well as the *United Nations Millennium Declaration*. Among key commitments, HIV/AIDS, Malaria, Tuberculosis and other health issues were addressed. Within the Declaration, world leaders committed to a massive scaling up of HIV prevention, treatment, and care with the aim of achieving the goal of **universal access to prevention, treatment, care and support by 2010** (see more about this target below). Leaders recognized that HIV/AIDS “pose severe risks for the entire world and serious challenges to the achievement of development goals.”

## **Regional Declarations**

There have been several regional declarations addressing various aspects of HIV/AIDS over the years. Here follows two examples of important initiatives addressing the epidemic from a regional perspective.

### ***The Abuja Declaration on HIV/AIDS, TB and Other Infectious Diseases (2001)***

Following a special summit dedicated to the challenge of HIV/AIDS, TB, and Other Infectious Diseases in Abuja, Nigeria April 2001, *The Abuja Declaration* was ratified by the Heads of State and Governments of the Organization of African Unity (now the African Union).

The Declaration illustrates specific concerns about behaviors and conditions which increase vulnerability across the region, including the vulnerability of women, children and young people, and injecting drug users. It also acknowledges that poverty, poor nutrition, and underdevelopment can increase vulnerability to infection and increase the actual impact of the disease. It recognizes that war, conflicts, natural disasters and economic factors can increase migration and make people vulnerable to HIV infection, and that stigma, silence and HIV denial can undermine responses to the disease.

Through the Declaration, heads of state committed to placing the fight against HIV/AIDS at the forefront of national development plans through comprehensive multisectoral strategies. They also distinguished AIDS as a "State of Emergency in Africa", calling for all economic barriers to funding AIDS-related activities to be lifted. In order to strengthen the response to HIV/AIDS in the region, the African leaders pledged to set a target of **allocating at least 15% of annual budgets to the improvement of the health sector**, and to mobilize human, material, and financial capital to provide care and support to those living with HIV/AIDS.

### ***Progress on the Abuja Declaration***

Since the signing of the *Abuja Declaration*, the heads of state and governments of the

African Union have gathered on several occasions to analyze and debate the status of HIV/AIDS in sub-Saharan Africa, for example in Maputo, Mozambique in 2003 and once again in Abuja in 2006. These meetings were held to review the achievements made, to identify gaps, constraints and challenges to the realization of the Abuja Declaration and the MDG targets; to identify new strategies that will enable a new and more realistic course for Africa towards achieving these targets; to obtain renewed commitment by African Leaders for addressing these diseases; and promoting health and well-being in Africa among others. The latter meeting resulted in the *Abuja Call for Accelerated Action Towards Universal Access to HIV/AIDS, Tuberculosis and Malaria Services in Africa*. Although progress can be noted in the proportion of national budgets allocated to health, the need for intensified efforts and comprehensive programs for prevention, treatment, care and support, as well as practical leadership and coordinated partnerships at regional, national and local levels were stressed.

### ***Parliamentarians and the Abuja Declaration***

The *Abuja Declaration* and its follow-up declarations are important tools for African parliamentarians as they address the specific needs and challenges of sub-Saharan Africa. Particularly in the area of budget allocation, parliamentarians can use the Abuja 15% target to ensure that national budgets reflect this commitment and provide appropriate funds to the health sector. The Declarations also provide a list of guiding principles that can serve as a useful tool for developing and monitoring programs for disease mitigation. This can help parliaments in their own responses to HIV/AIDS, but can also be used to encourage their respective governments to live up to the commitments made through the Abuja Declaration.

### ***The Suva Declaration (2004)***

In 2004, *the Pacific Parliamentary Assembly on Population and Development* convened in Suva, Fiji with over eighty parliamentarians and delegates from nineteen countries and territories in the region to discuss, debate and deliberate issues related to HIV in the pacific region. Also present were seventy HIV/AIDS advocates who encouraged parliamentarians to become leaders in their communities. The meeting culminated in the signing of the *Suva Declaration*. Much like other international and regional initiatives, the

*Suva Declaration* explicitly states commitment to addressing the needs of vulnerable groups, including women and girls; socio-economic factors which increase the spread of HIV/AIDS; the need for multisectoral approaches which fosters strong political leadership, partnerships, and the inclusion of civil society; advocacy; resource mobilization; and legislative action. The Declaration also takes in consideration the specific regional context and stresses the need to respect local culture and traditions.

### ***Parliamentarians and the Suva Declaration***

This meeting was specifically targeted to parliamentarians in the region as decision-makers who can influence and engage in this process and serve as leaders to generate understanding and consensus concerning HIV/AIDS responses in the Pacific Region. Until recently, the Pacific had not experienced the same number of infections as seen in other regions, undermining the urgency to respond. Now that infection rates are to increasing, it is important for parliamentarians to take a proactive response to the issue, drawing from lessons and experiences of other countries.

Through the Suva meeting parliamentarians were able to learn basic information about HIV/AIDS, to discuss their role in promoting the response to HIV/AIDS in their region. Parliamentarians were encouraged to develop regional strategies which were “far-sighted and all encompassing” with a vision, goal, and principles based on the importance of strong leadership. Empowering parliamentarians in the region to react to the pandemic and bringing them together with HIV/AIDS activists worked as a strategy to ensure political support and action at a high level to increase the likelihood of success.

## International Strategies to address HIV/AIDS

### **The ABC Approach**

The ABC campaign takes on different meanings with different organizations. The popular ABC slogan is believed to have been developed in Botswana in the late 1990s for a public AIDS awareness campaign:

"Avoiding AIDS is as easy as...

**A**bstain

**B**e faithful

**C**ondomise"

Source: [www.avert.org/abc-hiv.htm](http://www.avert.org/abc-hiv.htm)

The approach aims to change individual behavior and was also used successfully in Uganda to encourage sexual *Abstinence* until marriage; to advise those who are sexually active to *Be faithful* to a single partner or to reduce their number of partners; and to encourage always

using a *Condom*, especially among people with multiple partners. Some people claim that it was the main reason for Uganda's unique success in reducing its HIV prevalence. This was not a new approach to reduce the risks for HIV-infection, rather a new way of putting across known risk reduction and risk avoidance strategies.

Since the original use of the ABC-slogan in Botswana, there have been other variations put forward with more specific definitions of the ABCs , the most well known being those adopted by the US-funded President's Emergency Plan For AIDS Relief (PEPFAR) and UNAIDS.

PEPFAR chooses to emphasize:

- **A**bstinence for youth, including the delay of sexual debut and abstinence until marriage;
- **B**eing tested for HIV and being faithful in marriage and monogamous relationships;
- **C**orrect and consistent use of condoms for those who practice high-risk behaviours.

While USAID choose to use the following definition:

- **A**bstinence or delaying first sex;

- **Being safer by being faithful to one partner or by reducing the number of sexual partners;**
- **Correct and consistent use of condoms for sexually active young people, couples in which one partner is HIV-positive, sex workers and their clients, and anyone engaging in sexual activity with partners who may have been at risk of HIV exposure.**

These different definitions have created some controversy, in particular the PEPFAR version, which does not promote condom use for youth, or anyone outside high-risk groups. The emphasis on abstinence until marriage, has also been criticized. Research has shown that abstinence until marriage does not always ensure safety, because marriage in itself provides no protection from infection as it does not always guarantee monogamy by the partner. Neither is abstinence a realistic option for the millions of women and girls who are in abusive relationships, nor for those who have been taught always to obey men. It has therefore been stressed by critics that people who do not abstain should do everything possible to reduce risk, including using condoms, which has proven to be effective in preventing HIV infection, if used correctly and consistently.

### ***Progress of the ABC Campaign***

Uganda is usually used as an example to show the success of the ABC-approach, as it successfully managed to reduce the number of new infections between the late 1980s and mid 1990s. For example, HIV prevalence among pregnant women went down from around 30% in 1992 to around 6.5% in 2003 ([www.kaisernetwork.org](http://www.kaisernetwork.org)). Aggressive media campaigns were launched in Uganda to address the rapid increase of HIV prevalence in the country, involving posters, radio messages and rallies, which were adjusted according to the specific needs of different groups. They encouraged young people to wait for sex, or return to abstinence if already sexually active; used the message "zero grazing", which is slang for "don't have casual sexual relationships", and encouraged people to stay with regular partners; and condoms were promoted to the population as a whole.

Although incorporating some elements of abstinence, being faithful and using condoms, the actual term “ABC” does not seem to have been used to a great extent in Uganda. Also, the ABC concept itself cannot sufficiently describe what happened in Uganda. **Immediate and strong political leadership combined with swift, powerful and wide-ranging action**, in particular by President Yoweri Museveni, was of great importance. The action that was taken to encourage people to speak frankly and openly about HIV/AIDS in order to reduce stigma and discrimination; to mobilize and involve the communities; to involve local organizations and businesses; to enable wide spread HIV testing and counseling as well as treatment of STIs; and to promote gender equality all played a pivotal role in the success of Uganda’s HIV/AIDS response. The **combination of messages and approaches, including the widespread promotion and distribution of condoms**, might better describe what worked in Uganda than the ABC campaign alone.

There have been several calls to look beyond the “ABC” approach in fighting HIV/AIDS. The main criticism is that this approach does not consider the situation many women and girls in developing countries find themselves in and focuses on issues that are often out of women’s control. Research has shown that HIV/AIDS has a disproportionate impact on women and girls, compared to men and boys. Many of them live in areas where sexual abuse and exploitation of women and girls are widespread. They are therefore not in a position to choose if they want to abstain from having sex or to negotiate condom use. Many married women also become infected by their partner, even if they themselves have remained faithful. Some then argue that “ABC” is insufficient without a **“D” for disclosure**, that is the importance of knowing your status, changing your behavior appropriately, and living positively. They also argue that this needs to be combined with safety measures to protect the women who do disclose their status. In addition, by adding **“E” for education**, women’s vulnerability to infection due to lack of access to education could be reduced. In practice, this would mean appropriate curricula on HIV/AIDS in schools, informal community-driven training, scholarships and skills training for women and girls from AIDS-affected communities, and keeping schools safe for girls. This should also be combined with **“F” for female**

**controlled prevention** methods, such as microbicides and female condoms for when they do not have the power to negotiate (See Unit 10 - HIV and Gender).

### ***Importance of the Approach***

Although the ABC approach has been criticized for various reasons, it has still been one of the most wide spread prevention messages used in the fight against HIV/AIDS. Where a balanced and widespread approach has been tailored to local circumstance, it has contributed to reducing new infections at the national or sub-national level. In Thailand and Cambodia, a “100 percent condom use” government policy in brothels led to a sharp reduction in the spread of HIV, as well as steep declines in the number of men paying for sex by more than 50% in Thailand and 40% in Cambodia. In Kenya, between 1998 and 2003 there was a positive decline in HIV prevalence due to changes in sexual behavior with fewer unmarried young men and women having sex, less men and women engaging in sexual activities with multiple partners and increased condom use.

### **UNAIDS - Global Strategy Framework on HIV/AIDS (2000)**

The Joint United Nations Programme on HIV/AIDS, UNAIDS, is a joint venture of the United Nations family, bringing together the efforts and resources of UNHCR, UNICEF, WFP, UNDP, UNFPA, UNODC, ILO, UNESCO, WHO and the World Bank in the AIDS response to help the world prevent new HIV infections, care for people living with HIV, and mitigate the impact of the epidemic.

The *Global Strategy Framework* was developed by UNAIDS in 2000 to present basic steps necessary for HIV/AIDS mitigation, including the importance of reducing infection, vulnerability, and impacts, and illustrates that effective HIV/AIDS interventions require a high degree of coordination among different sectors and that integrating the voices, needs, and experiences of national governments with the international community is seen as a basic step to successfully combat HIV/AIDS.

The *Global Strategy Framework* is not a detailed blueprint. It calls on global, national, and community bodies to formulate their own specific strategies concerning particular

themes or regions and requires a change in conduct at the community, national, and international level, just as individuals must change their personal behavior. At the core of the Strategy stands the conviction that tackling the epidemic is an indisputable, global priority, and that an expanded, extraordinary response is not simply necessary, but feasible.

The *Global Strategy Framework* asserts that “when these principles are applied to local responses, and when political leadership exists to greatly increase local responses on a national scale, the epidemic can be reversed.”

**The aim of the *Global Strategy Framework* is to:**

- Support communities and countries to reduce risk and vulnerability to infection;
- Save lives and alleviate human suffering;
- Lessen the epidemic’s overall impact on development.

The principles of the *Global Strategy Framework* are informed and guided by the respect, protection, and fulfillment of human rights. It is based on four fundamental principles:

- **The role of national governments**, working with civil society, to provide leadership, means and coordination for national and international efforts to respond to country and community needs;
- **Support for the active engagement** of people living with and affected by HIV/AIDS in communities around the world;
- **Explicitly address** gender inequalities fuelling the epidemic;
- **Equitable and affordable availability** of prevention methods, life saving treatments and the results of scientific breakthroughs. (Global Strategy Framework, UNAIDS 2001).

***Progress***

The *Global Strategy Framework* is based on the belief that prevention, treatment and support are equally integral to reversing the pandemic and that a coordinated response is imperative in simultaneously reducing the risk of new infection, vulnerability, and

impact of the disease among households and communities. It has also become increasingly apparent that the interrelation between these factors must be addressed in order to make any reasonable gains. In its efforts to promote a coordinated response to the HIV/AIDS pandemic, UNAIDS have used the *Global Strategy Framework* as a base for all its support activities. This includes support to individual countries like Zambia during the development of its 2007-2010 National Development Plan, as well as support to other UN agencies, such as the United Nations Educational, Scientific and Cultural Organization (UNESCO) and the International Fund for Agricultural Development (IFAD) in their HIV/AIDS strategies.

The *Global Strategy Framework* identified and documented several important lessons learned over the first 20 years of HIV/AIDS mitigation:

1. The scale of the pandemic is far greater than 20 years ago, exceeding the worst case projections made at the time.
2. The major impact of the pandemic is yet to come.
3. Considerable success has been demonstrated in addressing the epidemic.
4. An even greater pandemic can be prevented in the future.
5. Capacity and commitment to act has increased.
6. HIV/AIDS care and support have become more effective.
7. Successful responses to the epidemic have their roots in communities.
8. People living with HIV/AIDS are central to the response.

Although these lessons and outcomes may require revision, as areas become improved or worsen and vary according to region over time, these lessons still highlight some key areas for consideration and can guide parliamentarians and others in future HIV/AIDS responses.

### **GIPA – Greater Involvement of People Living with HIV**

GIPA is a principle that aims to realize the rights and responsibilities of people living with HIV (PLWHA), including their right to self-determination and participation in decision-

making processes that affect their lives. By greater involvement of PLWHA, GIPA aims to enhance the quality and effectiveness of the AIDS response.

The GIPA principle was first formalized at the 1994 Paris AIDS Summit, when 42 countries agreed to “support a greater involvement of people living with HIV at all...levels...and to...stimulate the creation of supportive political, legal and social environments” (From Principal to Practice, 1999). The GIPA principle was also endorsed by leaders through the Declaration of Commitment on HIV/AIDS in 2001 and by the Political Declaration on HIV/AIDS in 2006.

*People living with HIV must be at the forefront of the response because they are living with HIV each and every day. You cannot plan for them; you have to plan with them! Political leaders have to stand up for the rights of people living with HIV by enacting laws, budgeting for programmes to support them and also by speaking up in ways that will normalize HIV.*

**Hon. Lediana Mafuru Mng’ong’o, Member of Parliament, Tanzania: Chair CAPAH; and Chair, TAPAC**

PLWHA have directly experienced the factors that make individuals and communities vulnerable to HIV infection, as well as HIV-related illnesses and strategies for managing them. Therefore, their involvement in program development and implementation, as well as policy-making, can improve the relevance, acceptability and effectiveness of programs.

However, there are several challenges to achieve GIPA. Some the challenges faced by of the organizations and networks representing PLWHA have been weak management, low skill levels, funding constraints, difficulties in representing the diversity of PLWHA. There are also many social barriers affecting the implementation of GIPA which are often rooted in poverty, gender inequality, homophobia and other forms of prejudice. UNAIDS stresses the need for all actors to ensure that PLWHA have the space and practical support for a greater and more meaningful involvement.

## **Box 2**

### **How Can People Living with HIV be Involved?**

**Personal:** People living with HIV are actively involved in their own health and welfare. They take an active role in decisions about treatment, self education about therapies, opportunistic

infections and adherence, and positive prevention.

**Campaigns and public speaking:** People living with HIV are spokespersons in campaigns or speakers at public events and in other arenas.

**Treatment roll-out and preparedness:** People living with HIV support treatment roll-out through educating others on treatment options, side effects and adherence, and are involved as home-based and community health-care.

**Advocacy:** People living with HIV advocate law reform, inclusion in the research agenda and access to services, including treatment, care and support; and for resource mobilization for networks of people living with HIV and for the broader response.

**Policy-making process:** People living with HIV participate in the development and monitoring of HIV-related policies at all levels.

**Programme development and implementation:** People living with HIV provide knowledge and skills towards universal access through participation in the governance of global organizations such as UNAIDS and the Global Fund and in the choice, design, implementation, monitoring and evaluation of prevention, treatment, care and support programmes and research.

**Leadership and support, group networking and sharing:** People living with HIV take leadership of HIV support groups or networks, seek external resources, encourage participation of new members or simply participate by sharing their experiences with others.

**Source:** *The Greater Involvement of People Living with HIV – Policy Brief, 2007*

### **WHO and UNAIDS – The “3 by 5” (2003) and Universal Access by 2010 (2005) Initiatives**

On World AIDS Day, December 1<sup>st</sup> 2003, the World Health Organization (WHO) and the Joint United Nations Programme on HIV/AIDS (UNAIDS) unveiled a detailed and concrete plan to reach the “3 by 5” target, of providing antiretrovirals (ARVs) **to three million people, by 2005**. The “3 by 5” initiative was developed to address the urgent need to treat the millions of people living with HIV/AIDS in the developing world, providing life saving treatments to those who would normally be unable to afford it. At that time (2003), of the 6 million people who needed ARVs in the developing world, less than 8% were receiving it.

With a unique focus on treatment, WHO/UNAIDS promoted the use of ARVs for a variety of reasons, moving beyond “cost effective” prevention strategies which were typically employed. What the initiative effectively demonstrated, is that in order to combat the

disease concerted efforts, that is prevention AND treatment, needed to be made immediately available.

### **Box 2**

#### **Why "3 by 5"?**

ARVs work because they:

- Prolong lives, making HIV a chronic disease, and not a death sentence;
- Calm anxieties about the disease, decreasing fatalism and encouraging higher rates of HIV testing, due to changing attitudes;
- Can reduce rates of HIV transmission as part of other prevention strategies, such as condom use;
- Are now significantly more affordable due to increased production of generic drugs;
- Can reduce illness and restore quality of life;

**Source:** [www.who.int/3by5/about/initiative](http://www.who.int/3by5/about/initiative)

In order to achieve the goal of 3 million, by 2005, WHO and UNAIDS committed to several critical areas to ensure that more individuals were being testing, and effectively treated for HIV. This included simplified and standardizing testing and tools to deliver medicines; the improvement of infrastructure to ensure effective, reliable health care services; the dissemination of global knowledge and success strategies to improve country responses; and urgent and sustained support for all countries, including through advocacy.

The "3 by 5" Initiative did not fully reach its goal of 3 million recipients on treatment by 2005. However, the initiative played an important role in increasing access to ARVs in low- and middle-income countries between 2003 and 2005, where overall global treatment increased three-fold. Important lessons were also learned in order to improve future responses and access to treatment based on the principles of urgency, equity, and sustainability.

#### **Universal Access by 2010**

In July 2005, leaders of the Group of Eight (G8) countries (Canada, France, Germany, Italy, Japan, Russia, the UK and the US) pledged to ensure as near as possible to

universal access to ARV treatment worldwide by 2010. Two months later, all United Nations Member States endorsed this goal by committing themselves to:

*"Developing and implementing a package for HIV prevention, treatment and care with the aim of coming as close as possible to the goal of universal access to treatment by 2010 for all those who need it"* (World Summit Outcome Document, 2005)

This promise was reaffirmed by the world's leaders through the Political Declaration on HIV/AIDS at the UN High-level Meeting on AIDS in 2006:

*"[We commit] to pursue all necessary efforts to scale up nationally driven, sustainable and comprehensive responses ... towards the goal of universal access to comprehensive prevention programmes, treatment, care and support by 2010."* (Political Declaration on HIV/AIDS, 2006)

African leaders made additional commitments to universal access at a meeting in Abuja, Nigeria in May 2006. According to Nigerian President Olusegun Obasanjo, the leaders agreed to achieve "100 percent access to preventive and treatment services" ([www.aegis.com/NEWS/AFP/2006/AF060510.html](http://www.aegis.com/NEWS/AFP/2006/AF060510.html)).

WHO and UNAIDS have since defined a concept and a framework for universal access to HIV/AIDS prevention, treatment and care by 2010 and put a system in place to monitor progress. In the 2006 progress report called *Towards Universal Access*, it was estimated that 1.65 million people living with HIV were receiving treatment in low- and middle-income countries, representing 24% of the total people in need of treatment. In sub-Saharan Africa, where 63% of all people receiving treatment in the developing world reside, more than **1 million people had access to life saving drugs in 2006, compared to just 100,000 in 2003**. According to the 2008 follow-up report, **in 2007** it was estimated that **3 million people had access to antiretroviral therapy**. In that year alone, one million people started treatment; the access to drugs to prevent mother-to-child transmission of HIV improved; testing and counseling expanded; and the commitment to male circumcision in some of the heavily affected regions of sub-Saharan Africa increased. This rapid increase was possible because of increased availability of drugs, due to a large extent to price reductions; improved delivery systems; and the increased demand, due to rising numbers of people tested and diagnosed with HIV.

However, despite these positive increases, there were 2.5 million new HIV infections during 2007 and there are still an estimated 6.7 million people in need of treatment who still cannot access these life-saving drugs. Other challenges identified in the report were weak health systems; a shortage in health workers; a lack of sustainable long term financing; and weak information systems. The urgent need for enhanced political commitment, better coordination and additional research to address some of these challenges was also stressed.

### **UNAIDS - The "Three-Ones" (2004)**

In recent past, AIDS activists focused largely on generating political commitment, leadership, and funding in response to the pandemic. As these financial resources became increasingly available, the need to develop efficient strategies to mobilize these resources became apparent. In 2004, US\$6.1 billion was available for HIV/AIDS programming in developing countries – yet rates of new HIV infections and deaths due to AIDS continue to rise due to an inadequate *use* of funding, resulting from a lack of coordination between the international, national and community based responses to the pandemic. The "Three Ones" were developed as an attempt to coordinate multisectoral initiatives and responses to HIV/AIDS, build capacity among national and regional leaders, and to improve the inadequate use of funding observed by the United Nations.

#### **Box 3**

#### **The "Three-Ones"**

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

[www.unaids.org/en/CountryResponses/MakingTheMoneyWork/ThreeOnes](http://www.unaids.org/en/CountryResponses/MakingTheMoneyWork/ThreeOnes)

### ***Progress***

In 2004, representatives from donor and host countries and major international organizations formally endorsed the "Three Ones," and agreed to collaborate and put the "Three Ones" into practice, with the help of UNAIDS as a facilitator and mediator. However, at the end of 2004, only 66 countries demonstrated their commitment to the

“Three Ones” principles, and were able to report on the extent to which they were applied to their own national AIDS strategy plans. Of the total 66 countries, nine were in Latin America, 13 in Oceania, 11 in Europe and Central Asia, five in the Middle East in North Africa – and 28 in sub-Saharan Africa. UNAIDS Country Annual Reports found that 81% of the countries had up to date national AIDS framework, 95% had coordinating authorities, and 77% had initiated working groups to develop national monitoring and evaluation systems.

Although these structures exist, many countries struggle to fully implement monitoring and evaluation systems and to put funding to best use. At the national level, this requires both an understanding of the unique dimensions of the pandemic within individual countries, including strengthening human capacity to gather and analyze data, and improving the disbursement of funding and services for those in need. In addition, strong political leadership, full participation by other stakeholders such as civil society and non-health ministries is also needed to ensure a comprehensive and efficient application of the “Three Ones.”

Furthermore, a national AIDS framework requires that budgets and work plans account for specific sources and allocations of funds. Without this, donors may be hesitant to release funding. Setting and monitoring budgets is the best way to ensure that spending is coordinated with program objectives (see Unit 6 for important budgetary considerations).

#### **Box 4**

#### **The UN’s commitment to the “Three Ones”**

Achieving the full application of the “Three Ones” principles is a key priority of the United Nations system. This system operates and thrives on the involvement of the UN Theme Groups, which serve to coordinate their activities at the country level through the UNAIDS Country Coordinators. The UN Theme Groups and individual UN agencies incorporate the “Three Ones” in their work plans. The UN Theme Groups and Country Coordinators communicate the UN headquarters of the need for increased, of unusual action in a region.

**Source:** *The “Three Ones” in Action, UNAIDS, 2005*

Finally, at the global and national level, more funding has been dedicated to evaluation and monitoring, due to the increased recognition that annual reports can improve the effectiveness of HIV/AIDS interventions in policy development, prevention, testing and treatment, and other care and support services for people living with HIV. Though most countries still need to improve monitoring and evaluation efforts, many are bridging gaps between governments, donors, civil society and the UN system in order to develop and achieve success indicators most appropriate for their country and its needs.

### ***Key lessons learnt***

The “Three Ones” is based on the belief that universal consensus is only as effective as the degree to which it is implemented at the national and local level. This approach relies on that each country considers the appropriate way to ensure effective participation in developing, reviewing and updating their respective national AIDS frameworks as well as to the involvement and acceptance of all stakeholders. Some key lessons have been identified in countries during their efforts to achieve the “Three Ones”:

- 1) Seek input from all stakeholders at the international, national, regional, and local levels. This includes engaging with people both infected and affected by HIV/AIDS;
- 2) Use the experiences of a multisectoral approach to develop and implement budgets;
- 3) Understand the needs of the country, communities and vulnerable groups within them;
- 4) Develop and budget for a system of monitoring and evaluation that can be used across the country. This is the best way to ensure that targets are being met, and that resources are responsibly allocated.

It is also emphasized that strong political leadership is needed to develop and monitor HIV/AIDS mitigation programs and responsible spending, as well as to ensure the inclusion of marginalized groups. It is recommended that each country adhere to a single set of standardized evaluation indicators to facilitate the monitoring of national progress and to ensure effective flows of information and understanding between all stakeholders at the national, district and local levels. Furthermore, firm budgets, and

adherence to a multisectoral approach, can help avoid repetition and reduce unnecessary spending, and hence assist in making better use of funds for prevention and treatment initiatives at all levels.

### **World Bank - AIDS Strategy and Action Plan (2006)**

The World Bank's AIDS Strategy and Action Plan (ASAP) is designed to support countries through advice and technical support for strategic HIV/AIDS actions planning. It was set up in 2006 to complement existing options for country assistance and to enable UNAIDS to better support prioritized, evidence-based, results focused on national AIDS strategies and annual action plans. According to its 2008 progress report, since 2006 ASAP has been active in 45 countries, mainly in sub-Saharan Africa, and has supported one regional initiative and three civil society networks.

The ASAP is supported by UNAIDS at the global, regional, and country level in all its areas of work, and also collaborates with ILO, UNICEF, UNFPA, UNDP and WHO. ASAP also relies on the technical skills and expertise of experienced consultants working in partner countries.

#### **ASAP constitutes a one-stop-shop that includes:**

- Rapid external reviews of draft strategies and action plans;
- Technical and financial support to develop strong strategies and action plans;
- Development of tools and guidelines to assist clients to assess and improve their strategies;
- Capacity building for policymakers, practitioners and consultants.

Currently, ASAP is receiving an increasing number of requests from National AIDS councils, UNAIDS regional support teams, and country coordinators to review and improve draft strategies and operational plans. After a request is filed, ASAP works to meet country needs and engages members of the ASAP Secretariat, ASAP Advisory Groups including major UN partners (ILO, UNDP, UNESCO, WHO, and UNAIDS), and the ASAP Technical Advisory Group which is represented by civil society, private sector donors, UN agencies and international consultants. Finally, the ASAP Training Advisory

Committee advises all core members, and makes recommendations concerning the level of technical expertise required, as well as training activities which could be beneficial for the parties involved.

### ***Progress***

ASAP was developed in order to further strengthen responses to HIV/AIDS at the national level. A review of previous strategies conducted among thirty-one countries by the World Bank revealed several key shortcomings in planning efforts. ASAP seeks to improve areas such as analytical underpinning and explicit prioritizing and build on the lessons learned from past HIV/AIDS mitigation strategies. In order for ASAP to gain continued relevance, the World Bank recommends that countries submit draft HIV/AIDS action strategies for review to help bring together international, national, and local priorities in a meaningful way. Without identifying key demographics, regions, and sectors for improvement, HIV/AIDS mitigation will be needlessly slowed. National AIDS Action Committees are indeed making solid progress of their own. However, the review conducted by the World Bank indicated that there are still areas for improvement. By sharing knowledge, including program failures, this highlights the best way to correct current problems and prevent them from being replicated in future planning.

### **Key International Funding Initiatives**

#### ***The Global Fund to Fight AIDS, Tuberculosis, and Malaria***

As of 2002, the Global Fund has been working to finance national and regional programs, committed to alleviating poverty and the impacts of HIV/AIDS, Tuberculosis, and Malaria. Its funding is made available through the financial support of various donor countries, and international foundations and organizations. The purpose of the Fund is not to implement programs, but to attract, manage, and disburse funds to nationally owned and controlled projects and to supplement already strong national and local initiatives, which have been previously hindered by a lack of financial resources.

#### **Guided by these principles the Fund will:**

- Make financial resources available to combat HIV/AIDS, TB, and Malaria;

- Base its work on programs that reflect national ownership, and respect country-led formulation and implementation;
- Operate in a balanced manner working in different regions, and focusing on all three diseases with a variety of interventions;
- Pursue balanced strategies, funding prevention, treatment, care and support programs;
- Evaluate proposals through an independent review board, and be flexible in considering local realities and priorities;
- Seek to establish a simplified, rapid, and innovative process with efficient and effective disbursement mechanisms, in a transparent and accountable manner based on clearly defined responsibilities.

Proposals are considered based on the ability to demonstrate awareness of best practices, and a commitment to scale up programming in the future in order to promote sustainability. Funding will also be disbursed based on high-level, sustained political involvement, and a commitment to multisectoral initiatives focusing on increasing health care coverage and the improvement of the overall health care delivery system. Examples of such programs that could be supported include:

- Increasing access to health services;
- Provision of health products including drugs, condoms, treatments for sexually transmitted infections, laboratory supplies, and diagnostic kits;
- Training of personnel and community health workers;
- Behavior change and outreach.

Community participation is another key concern, particularly by those infected and affected by the disease, including care for the ill and orphaned. Finally, the Fund will support strategies that focus on clear and measurable results.

### ***Progress***

The Global Fund has contributed to hundreds of programs initiated at the national and multisectoral level. By 2007 the Fund had distributed grants to 410 projects in 132 countries. The Global Fund commends itself for quickly disbursing funds.

According to its 2007 results report, the Global Fund has:

- Committed a total USD\$ **10.7 billion in 136 countries** to aggressively target all three diseases - 58% of funding was dedicated to HIV/AIDS;
- Increased the number of people on ARVs by 1.4 million;
- Reached 62 million people with voluntary counseling and testing services for HIV prevention;
- Supported over 1 million orphans through medical services, community support and care;
- Doubled the number of people receiving key services between 2005-2006, and the number of people receiving treatment for HIV and TB are continuing to increase steadily; and
- Dedicated 38% of funding to the 10 countries with the highest disease burden.

Other key successes have showed that of the programs funded, recipients were able to demonstrate that they had implemented and reached 94% of their programming targets including HIV testing and counseling, and health service training. Areas for improvement include the prevention of mother-to-child transmission. The Global Fund has been diligent in monitoring program improvement, and has reported that countries have been successful in "learning by doing", and adjusting their responses based on best practice experiences. Estimates indicate that The Global Fund will need approximately USD\$ 4 – 6 billion dollars annually to scale up services and offer sustained support to national initiatives. Achievements sponsored by the Global Fund have demonstrated that, with concerted political will and the provision of funding, national strategy plans to combat HIV can be fully realized. The Global Fund is therefore a crucial bridge between declarations, commitments, and financial reality.

### ***The U.S. President's Emergency Plan for AIDS Relief (PEPFAR)***

In 2003, during his State of the Union address, President George W. Bush announced the President's Emergency Plan for AIDS Relief (PEPFAR). PEPFAR is a multifaceted approach to combating the disease around the world, with an original commitment of \$15 billion across five years, and a final funding level of \$18.8 billion. This is the largest

commitment ever by any one nation for an international health initiative dedicated to a single disease.

PEPFAR is linked with the U.S. Five Year Global Strategy for HIV/AIDS, which defined the strategic direction of the programs to be supported. The objective of the strategy is to:

- Encourage bold leadership at every level to fight HIV/AIDS;
- Apply best practices within bilateral programs in concert with host governments' national HIV/AIDS strategies; and
- Encourage all partners to coordinate and adhere to sound management practices and harmonize monitoring and evaluation efforts.

PEPFAR supports the multisectoral national responses in host nations through the "Three Ones" principles (see above). Special focus is put on 15 focus nations, including Botswana, Cote d'Ivoire, Ethiopia, Guyana, Haiti, Kenya, Mozambique, Namibia, Nigeria, Rwanda, South Africa, Tanzania, Uganda, Vietnam, and Zambia, that are home to approximately 50% of the people living with HIV/AIDS. The goal is to ensure that 2 million HIV-infected people receive support treatment; that support is given to prevent 7 million new HIV infections; and that 10 million people infected and affected by HIV/AIDS, including orphans and vulnerable children can get support care through PEPFAR.

### ***Progress***

As of 2007, 94% of the funds had been committed and 59% expended. More than fifty-seven million people were reached by PEPFAR-supported prevention programs using the ABC approach (Abstain, Be faithful, correct and consistent use of Condoms) and from 2004 through 2007, the U.S. Government had supplied nearly 1.9 billion condoms worldwide and supported prevention of mother-to-child transmission (PMTCT) for women during more than 10 million pregnancies. In addition PEPFAR provided antiretroviral prophylaxis in over 827,000 pregnancies, preventing an estimated 157,000 infant HIV infections. Thirty three million people have received PEPFAR-supported HIV counseling and support as of 2007, and more than 6.6 million people infected or

affected by HIV/AIDS, including 2.7 million orphans and vulnerable children have received care under PEPFAR-sponsored programs. In addition, approximately 1.45 million men, women, and children have received PEPFAR funded ARV treatment.

PEPFAR has meant a substantial increase of funds to address the HIV/AIDS pandemic in Africa and elsewhere. By combining prevention, treatment and care in a comprehensive response, and by creating bilateral partnerships in the host countries as well as multilateral partnerships with the Global Fund and UNAIDS, PEPFAR has been able to have a big impact during a relatively short time period. However, PEPFAR has also been criticized for its heavy focus on abstinence in its prevention programs, which have included mandating that one-third of prevention spending be directed towards abstinence-only programs, as well as refusing to fund prevention programs aimed at sex workers or effective yet “taboo” safe needle exchange programs to prevent HIV transmission among drug users.

### **World Bank Multi-Country AIDS Program for Africa (MAP)**

The World Bank launched its Multi-Country HIV/AIDS Program for Africa (MAP) in September 2000. The purpose of this program is to dramatically increase access to HIV prevention, care and treatment programs. Emphasis is put on encouraging local action through community organizations, NGOs and the private sector as well as a cross-sectoral response at the government level to enable the expansion of programs focusing on preventing mother-to-child transmission, supporting children affected by AIDS and building capacity for treatment. Regional programs to address cross-border issues and sharing knowledge are also deemed important.

Due to the nature of the epidemic, this new approach emphasizes speed, flexibility, scaling up existing programs, building capacity and “learning by doing”. The approach relies on early monitoring and evaluation to determine the effectiveness and efficiency of the activities and hence if they should be expanded further, be stopped or required additional capacity building. Funding “good” programs quickly is considered more important than funding “best practices” with delayed results, which could mean even more HIV/AIDS victims. Multisectoral and multi-agency implementation systems are

used for partnerships in the private sector and with civil society. Country programs are designed to empower stakeholders with funding and decision-making authority; involve actors at all levels, from individuals and villages to regions and central authorities; provide support to the public and private sectors and civil society; and to encompass all sectors at the full range of HIV/AIDS prevention, care and support and mitigation activities.

MAP is using a combination of full grants and zero interest loans that are made available to African countries that meet its eligibility criteria of (1) having a strategic approach to HIV/AIDS, (2) having a high-level HIV/AIDS coordinating body, (3) agreeing to use accelerated implementation arrangements, and (4) agreeing to channel some of the project support to nongovernmental organizations, community and faith-based groups, and the private sector. According to the report *The Africa Multi-Country AIDS Program 2000-2006: Results of the World Bank's Response to a Development Crisis*, the Bank has provided US\$1.286 billion for HIV/AIDS in Africa in six years through MAP, which represents 47 percent of the Bank's global investment in HIV.

### ***Progress***

MAP has had a substantial impact on national efforts to address the HIV/AIDS pandemic. According to the 2000-2006 report MAP has supported the following:

- **Preventing new infections** Services to prevent mother-to-child HIV transmission have been offered to 1,546, 388 women in 23 countries; 1,298,410, 996 condoms have been distributed in 25 countries; 1,512 new counseling and testing sites have been set up in 17 countries; almost seven million people in 25 countries have been tested; and over 2.2 million workers in 23 countries have been reached with HIV awareness and care programs in the workplace;
- **Mitigating the impact of AIDS** The work to prevent and care for 50,000 communities, civil society and youth groups, and organizations of people living with HIV have been financed throughout the MAP countries; and 1,779,872 orphans and other vulnerable children in 21 countries affected by AIDS have been offered care and support;

- **Providing treatment** Nearly 300,000 people in 20 countries have received treatment for opportunistic infections; anti-retroviral (ARV) drugs have been financed for close to 30,000 of the 554,648 people in 27 countries who are currently on ART; over 500,000 people have been trained and health systems that helped to roll-out ARV treatment strengthened in recent years as drugs prices fell and donor financing rose significantly.

### ***Future Support***

The MAP approach represents the first phase of a long-term World Bank commitment to support national HIV/AIDS responses in Africa. In its recent strategy document “*The World Bank’s Commitment to HIV/AIDS in Africa: Our Agenda for Action, 2007–2011*”, next stage in its engagement on HIV/AIDS in Africa is presented. The Agenda for Action (AFA) will rest on four pillars:

- *Pillar 1: Focus the response, through evidence-based and prioritized HIV/AIDS strategies.*
- *Pillar 2: Scale up targeted multisectoral and civil society responses.*
- *Pillar 3: Deliver more effective results through increased country monitoring and evaluation capacity.*
- *Pillar 4: Harmonize donor collaboration.*

Building on lessons learned, the AFA will use a more selective, strategic focus. The agenda will center on strong partnerships with governments, communities, the private sector, donors, and other development partners and apply the Bank’s unique strengths—its focus on development, multisectoral and civil society engagement, analytical capacity, flexibility, ability to fill gaps, and capacity to serve as a source of long-term, predictable finance.

### **Parliaments and international funding for HIV/AIDS**

Many countries depend on external recourses to be able to address the HIV/AIDS epidemic effectively. However, Parliaments are rarely included in the discussions between international donors and their respective governments, and are therefore not able to influence the conditions to which the aid is given. In those cases where

parliament has to approve aid agreements, it often does not have sufficient time to analyze the actual terms of the agreement or provide input. In addition the total disbursement of aid by international donors is not always reflected in the national budget, making it difficult for parliaments to get a full view of available funding for HIV/AIDS as well as to hold the government accountable for their spending on HIV/AIDS related programs.

Parliamentarians should advocate for an increased role during these discussions with international donors, as they can provide important information on the needs of the citizens they represent. They should also demand to have access to information on all available funds for HIV/AIDS programming and its intended use, even if it is not included in the national budget.

### **Parliamentary Initiatives Against HIV/AIDS**

The importance of parliamentarians becoming more involved in the fight against AIDS to enact and improve relevant laws and policies as well as playing a critical role in mobilizing necessary resources has been stressed at various international conferences, for example during the United Nations General Assembly Special Session on HIV/AIDS in 2001. Over the years, several international and regional initiatives have been developed involving parliamentarians to address the HIV/AIDS pandemic. Here follow some examples:

#### **Association of European Parliamentarians for Africa (AWEPA)**

Although AWEPA does not have a specific parliamentary coalition or committee on HIV/AIDS, it has been promoting a focus on HIV/AIDS in its work by organizing various seminars, study visits and training workshops on HIV/AIDS related matters. For example, in 2001 AWEPA organized a conference called "Parliament and the AIDS Budget" in cooperation with UNICEF.

In 2004, AWEPA launched a multi-year campaign on children and HIV, also in cooperation with UNICEF and others. The goal was to scale up parliamentary efforts on

behalf of children, in the context of HIV. One of the activities was the *African-European Parliamentary Consultation on Children Orphaned and made Vulnerable by AIDS in Africa* which took place in Cape Town in September 2004. This resulted in the *Cape Town Declaration*, which contains guidelines on how parliamentarians can make a unique contribution to scaling up efforts on behalf of orphans and vulnerable children, as well as a plan of action.

By signing this declaration, parliamentarians committed themselves to:

- Increase awareness about HIV by speaking up about the issues in their communities;
- Review and, if necessary, amend all relevant legislation to ensure that the rights of children are protected;
- Secure resources for a massive and more effective response to the needs of orphans and vulnerable children.

In addition, the key recommendations from this declaration are also featured in the book called "*What Can Parliamentarians Do About HIV/AIDS – Actions for Children and Young People*".

### **Inter Parliamentary Union (IPU) Advisory Group on HIV/AIDS**

The IPU Advisory Group on HIV/AIDS was established in 2006, and is composed of a maximum of twelve members of national parliaments, appointed by the IPU President in consultation with the members of the Advisory Group and IPU member parliaments, on the basis of attested expertise in the field of HIV and AIDS.

The IPU Advisory Group seeks to offer guidance to its 147 member parliaments on the implementation of international commitments on HIV/AIDS. It also helps design information and training materials for parliamentarians; conducts field visits to learn lessons from national responses to HIV/AIDS which can be shared with the wider parliamentary community; and it expands the scope of the parliamentary response against HIV/AIDS by identifying more effective strategies.

It spearheaded the first **Global Parliamentary Meeting on AIDS**, which took place in Manila, Philippines in November 2007 on the theme *Parliaments and Leadership in combating HIV/AIDS*. As a result of this meeting a declaration was made in which parliamentarians committed to take strong leadership on HIV and AIDS especially within the areas of stigma and discrimination and access to affordable treatment. During this meeting a new handbook for parliamentarians called *Taking Action Against AIDS* was launched and discussed. This handbook was developed in cooperation with UNAIDS and UNDP and aims to assist parliamentarians to become leaders, take action and make informed decisions on HIV-related law and policy reform in order to scale up access to prevention, treatment, care and support.

### **Parliamentarians for Global Action (PGA)**

PGA is an international network of over 1300 legislators in more than 100 elected parliaments around the globe. The network aims to promote peace, democracy, the rule of law, human rights, sustainable development and population issues by informing, convening, and mobilizing parliamentarians to realize these goals. In its Sustainable Development and Health Program, PGA concentrates on policy advocacy for HIV/AIDS, sexual & reproductive health and coinfections in South Asian countries with parliamentarians and key partners such as Actionaid International, UNAIDS-Pakistan, UNDP, UNFPA and WHO. The activities undertaken by PGA members in South Asia have also been designed as a model for implementation in other regions and countries with accommodation of specific needs of the target population.

### **Commonwealth Parliamentary Association (CPA)**

CPA is working with the international community and Commonwealth parliaments to analyze the impact of HIV/AIDS and to determine how parliaments can play a leading role in alleviating its effects. In 2005 the CPA convened a Study Group on the Role of Parliamentarians in combating HIV/AIDS, which was hosted by the Parliament of India. The report from this meeting indicates ways in which parliamentarians can play their role in addressing the epidemic more effectively and put forward several recommendations for parliamentary action.

### **Coalition of African Parliamentarians Against HIV and AIDS (CAPAH)**

CAPAH is an independent pan-African network of parliamentarians committed to work together to increase their role in the response to the HIV/AIDS pandemic. The coalition was formed in 2006 to improve the advocacy, policymaking and oversight role of parliamentarians in order to increase African parliamentary participation in the fight against HIV and AIDS. This network provides an opportunity for members from across the continent to share lessons learned and develop a community of practice dedicated to strong HIV and AIDS leadership. It currently has six national chapters in Burundi, Ghana, Malawi, Tanzania, Zambia and Zimbabwe. The Parliamentary Centre is currently acting as its Secretariat.

### **Southern African Development Community Parliamentary Forum (SADC PF)**

SADC PF works closely with its member parliaments to strengthen the role of parliaments in combating HIV/AIDS, TB and malaria, diseases also with high mortality and morbidity rates that hamper development in the region. The forum also works to mainstream HIV/AIDS into all of its priority areas, including regional integration to improve consistency of responses, democracy and governance, gender equality, capacity building and inter-parliamentary cooperation and human rights.

SADC PF has established a Standing Committee on HIV/AIDS, whose Plan of Action for 2006-2010 aims to:

- Strengthen MPs' knowledge of prevention, treatment, care and support of HIV and AIDS, TB and Malaria;
- Accelerate the harmonization of legal frameworks at national and regional level of HIV and AIDS declarations and related government policies/legislation;
- Foster accountability, advocacy and oversight on the implementation of various HIV and AIDS, TB and malaria global, regional and sub-regional declarations;
- Encourage MPs to actively promote national commitments regarding universal access to treatment, care and support for people with HIV/AIDS, TB and malaria at the constituency level;
- Strengthen and mobilize national and regional political leadership to put orphans and vulnerable children at the centre of HIV and AIDS response;

- Strengthen regional coordination between countries to scale up cross border initiatives on HIV, AIDS, TB and Malaria.

### **Unit 3: Questions**

Please answer each of the following questions. If you are taking this course in a group you may then meet to discuss your answers.

1. Which key international and regional declarations address HIV/AIDS? Why are they important, and what impact have they had since their development? How can they be used by Parliament in its response to the pandemic?
2. Find out which of these declarations your respective governments have committed to and to what extent they are living up to these commitments.
3. What are the key international strategies and approaches to address the HIV/AIDS pandemic? Which ones have been used in your country and what was the result?
4. Which are the main major international funding mechanisms and how have they helped address HIV/AIDS?
5. Which international and regional parliamentary networks or initiatives have addressed HIV/AIDS? Has your parliament been involved in any of these activities, or addresses HIV/AIDS in similar ways?

### **Select Bibliography:**

*2008 Report on the global AIDS epidemic*, UNAIDS, 2008

*ASAP Progress Report: June 01, 2008*, World Bank, 2008

*Beyond "ABC": Helping Women Fight AIDS*, by Janet Fleischman, Washington Post, June 29, 2004

*Declaration of Commitment on HIV/AIDS and Political Declaration on HIV/AIDS: midway to the Millennium Development Goals - Report of the Secretary-General*, United Nations General Assembly, April 2008

*From Principle to Practice: Greater Involvement of People Living with or Affected by HIV/AIDS (GIPA). Best Practice Key Material*, UNAIDS, 1999

*Keeping the promise – Summary of the Declaration of Commitment on HIV/AIDS, UNAIDS, 2002*

*HIV/AIDS Slowing in Africa with Help from NGOS, Drugs and Condoms, Press Release No: 2007/433/HDN, World Bank, 2007*

*Parliament, Politics and AIDS – A comparative study of Five African Countries, IDASA/Parliamentary Centre, 2006*

*Partners in Impact - Results Report, the Global Fund, 2007*

*Preparing National HIV/AIDS Strategies and Action Plans - Lessons of Experience, World Bank, 2007*

*Taking Action Against HIV – A handbook for parliamentarians, IPU/UNAIDS/UNDP, 2007*

*The Africa Multi-Country AIDS Program 2000-2006 – Results of the World Bank's Response to a Development Crisis, World Bank, 2007*

*The Greater Involvement of People Living with HIV (GIPA) – Policy Brief, UNAIDS, 2007*

*The International Guidelines on HIV/AIDS and Human Rights – 2006 Consolidated Version, OHCHR and UNAIDS, 2006*

*The Millennium Development Goals Report 2007, United Nations, 2007*

*The Power of Partnerships: Fourth Annual Report to Congress on PEPFAR, 2008*

*The "Three Ones" in action: Where we are and where do we go from here, UNAIDS, 2005*

*The World Bank's Commitment to HIV/AIDS in Africa: Our Agenda for Action, 2007–2011, World Bank, 2008*

### **Internet resources:**

#### **International and Regional Declarations:**

The United Nations Millennium Declaration:

[www.un.org/millenniumgoals](http://www.un.org/millenniumgoals)

The Declaration of Commitment on HIV/AIDS:

[www.unaids.org/en/AboutUNAIDS/Goals/UNGASS/default.asp](http://www.unaids.org/en/AboutUNAIDS/Goals/UNGASS/default.asp)

The Political Declaration on HIV/AIDS:

[www.unaids.org/en/Conferences/2006HLM/default.asp](http://www.unaids.org/en/Conferences/2006HLM/default.asp)

The World Summit Outcome Document:

[www.un.org/summit2005](http://www.un.org/summit2005)

The Abuja Declaration on HIV/AIDS, TB and Other Infectious Diseases (2001):  
[www.un.org/ga/aids/pdf/abuja\\_declaration.pdf](http://www.un.org/ga/aids/pdf/abuja_declaration.pdf)

The Abuja Call for Universal Action (2006):  
[www.africa-union.org/root/au/conferences/past/2006/may/summit/doc/en/ABUJA\\_CALL.pdf](http://www.africa-union.org/root/au/conferences/past/2006/may/summit/doc/en/ABUJA_CALL.pdf)

The Suva Declaration:  
[www.spc.int/ppapd/index.php](http://www.spc.int/ppapd/index.php)

2008 High Level meeting on HIV/AIDS:  
[www.unaids.org/en/Conferences/2008HLM/](http://www.unaids.org/en/Conferences/2008HLM/)

### ***International Strategies to Address HIV/AIDS:***

The Global Strategy Framework:  
[www.unaids.org/en/KnowledgeCentre/Resources/Publications/PublicationsArchivePage6.asp](http://www.unaids.org/en/KnowledgeCentre/Resources/Publications/PublicationsArchivePage6.asp)

The WHO and UNAIDS “3 by 5” Initiative:  
[www.who.int/3by5/about/initiative](http://www.who.int/3by5/about/initiative)

Universal Access by 2010:  
[www.who.int/hiv/universalaccess2010/en/](http://www.who.int/hiv/universalaccess2010/en/)

The “Three Ones”:  
[www.unaids.org/en/CountryResponses/MakingTheMoneyWork/ThreeOnes/](http://www.unaids.org/en/CountryResponses/MakingTheMoneyWork/ThreeOnes/)

The World Bank AIDS Strategy and Action Plan:  
[www.worldbank.org/ASAP](http://www.worldbank.org/ASAP)

### ***International Funding Initiatives:***

The Global Fund: [www.theglobalfund.org](http://www.theglobalfund.org)

PEPFAR: [www.pepfar.gov](http://www.pepfar.gov)

The World Bank MAP: [www.worldbank.org/afr/aids/](http://www.worldbank.org/afr/aids/)

### ***Parliamentary Initiatives Against AIDS:***

AWEPA: [www.awepa.org](http://www.awepa.org)

CAPAH: [www.parlcent.ca/africa/CAPAH/index\\_e.php](http://www.parlcent.ca/africa/CAPAH/index_e.php)

CPA: [www.cpahq.org/default.aspx?id=3132](http://www.cpahq.org/default.aspx?id=3132)

IPU Advisory Group on HIV/AIDS: [www.ipu.org/splz-e/unaid07/flyer.pdf](http://www.ipu.org/splz-e/unaid07/flyer.pdf)

Parliamentarians for Global Action: [www.pgaction.org](http://www.pgaction.org)

SADC PF: [www.sadcpf.org/aids/index.php?disp=fiveyear.php](http://www.sadcpf.org/aids/index.php?disp=fiveyear.php)

***Other Internet Resources:***

[http://en.wikipedia.org/wiki/President's\\_Emergency\\_Plan\\_for\\_AIDS\\_Relief](http://en.wikipedia.org/wiki/President's_Emergency_Plan_for_AIDS_Relief)

[www.avert.org/abc-hiv.htm](http://www.avert.org/abc-hiv.htm)

[www.avert.org/aidstarget.htm](http://www.avert.org/aidstarget.htm)

[www.awepa.org/awepa-news/new-ipu-handbook-for-parliamentarians\\_en.html](http://www.awepa.org/awepa-news/new-ipu-handbook-for-parliamentarians_en.html)

[www.ipu.org/english/handbks.htm#aids07](http://www.ipu.org/english/handbks.htm#aids07)

[www.positivelypositive.ca/articles/aids-declaration.html](http://www.positivelypositive.ca/articles/aids-declaration.html)

[www.usaid.gov/our\\_work/global\\_health/aids/News/abcfactsheet.html](http://www.usaid.gov/our_work/global_health/aids/News/abcfactsheet.html)

[www.who.int/mediacentre/news/releases/2008/pr16/en/index.html](http://www.who.int/mediacentre/news/releases/2008/pr16/en/index.html)

[www.ipu.org/splz-e/haid07.htm](http://www.ipu.org/splz-e/haid07.htm)

[www.kaisernetwork.org](http://www.kaisernetwork.org)

[www.aegis.com/NEWS/AFP/2006/AF060510.html](http://www.aegis.com/NEWS/AFP/2006/AF060510.html)

**Suggestions for further reading:**

*Follow-up to the 2006 Political Declaration on HIV/AIDS 2007-2010 - Strategic Framework for UNAIDS support to countries' efforts to move towards universal access, UNAIDS, 2007*

*Mainstreaming HIV and AIDS in Sectors & Programmes - An Implementation Guide for National Responses, UNAIDS, the World Bank and UNDP, 2005*

*Scaling-up the HIV/AIDS response: From alignment and harmonisation to mutual accountability, ODI Briefing Paper, 2006*

*What Parliamentarians Can Do About HIV/AIDS – Action for Children and Young People, UNICEF, 2003*