

Combating AIDS in the developing world

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UN Millennium Project
Task Force on HIV/AIDS, Malaria, TB, and
Access to Essential Medicines
Working Group on HIV/AIDS
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Foreword

The world has an unprecedented opportunity to improve the lives of billions of people by adopting practical approaches to meeting the Millennium Development Goals. At the request of the UN Secretary-General Kofi Annan, the UN Millennium Project has identified practical strategies to eradicate poverty by scaling up investments in infrastructure and human capital while promoting gender equality and environmental sustainability. These strategies are described in the UN Millennium Project's report *Investing in Development: A Practical Plan to Achieve the Millennium Development Goals*, which was coauthored by the coordinators of the UN Millennium Project task forces.

The task forces have identified the interventions and policy measures needed to achieve each of the Goals. In *Combating AIDS in the Developing World*, the Working Group on HIV/AIDS underscores the importance of scaling up both essential HIV prevention services and antiretroviral treatment. Only urgent expansion of treatment can prolong the lives of the nearly 40 million people who already carry HIV—and will limit the social and economic devastation their deaths would cause. Only reinvigorated and expanded prevention can ultimately bring the epidemic under control. In the hardest hit countries, much more must also be done to mitigate the impact of the epidemic, especially on orphans and other vulnerable children. The key to scaling up HIV/AIDS services, particularly antiretroviral treatment, will be sustained investment in health systems, especially the healthcare work force.

This report was prepared by a group of leading experts who contributed in their personal capacity and volunteered their time to this important task. I am

very grateful for their thorough and skilled efforts. I am sure that the report, with its practical options for action, will make an extremely important contribution to bringing the AIDS epidemic under control and helping to achieve the Millennium Development Goals.

Jeffrey D. Sachs
New York
January 17, 2005

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Preface

The Millennium Development Goals, derived from the Millennium Declaration adopted by world leaders at the 2000 Millennium Summit, have evolved into an organizing theme of UN development work as well as a common framework for both donor and developing nations. In 2002 the United Nations Secretary-General and the United Nations Development Programme launched the UN Millennium Project to recommend the best strategies for reaching the Millennium Development Goals. The Millennium Project's Task Force on HIV/AIDS, Malaria, TB, and Access to Essential Medicines, concerned with Millennium Development Goal 6 on combating HIV/AIDS, malaria, and other diseases, consists of four operationally independent working groups focusing on HIV/AIDS, malaria, tuberculosis, and access to essential medicines.

The mandate of the Working Group on HIV/AIDS is to recommend strategies for reaching the Millennium Development Goal for HIV/AIDS and its accompanying target: "Have halted by 2015, and begun to reverse, the spread of HIV/AIDS." Since the Goal and official target provide little guidance, we have as a first step proposed an interpretation of the Goal based on more specific targets of our own devising. In analyzing how these targets could be reached, we have focused on identifying successful approaches and on overcoming obstacles to their implementation and expansion, rather than on devising new approaches or technical means. While improved prevention and treatment methods are vitally important, there is a clear imperative to deploy more broadly and effectively those that we already have in hand.

The resolution of the 2001 UN General Assembly Special Session on HIV/AIDS lays out the general principles of a global response to AIDS and commits member states to a series of steps. The working group has sought to complete the work of identifying the most effective measures and to consider institutional and technical arrangements for implementing them. The framework of

the Millennium Development Goals gives the UN Millennium Project a more ambitious and somewhat longer term perspective than many other initiatives. Accordingly, the working group has sought to emphasize the steps that will be required to reach ambitious goals for 2015, while recognizing the need for immediate progress.

The Millennium Project is an advisory body to the UN Secretary-General, and the United Nations system is clearly one audience for the working group's report. And, indeed, we offer some recommendations for how the UN system could more effectively assist countries to combat AIDS. But if our report is to contribute to achieving the Millennium Development Goals, it clearly must reach a broad spectrum of individuals and institutions concerned with the epidemic, from donor nations to developing country governments, nongovernmental organizations, and activists. We hope that the report will be useful to specialists and policymakers as well as intelligible to a broader audience.

Our AIDS report is best considered part of a broader body of analysis and recommendations; several topics important to the fight against AIDS are considered in greater depth in other reports of the UN Millennium Project. On questions of pharmaceutical pricing, access, and intellectual property rights, we have largely deferred to the Working Group on Access to Essential Medicines of our own working group. Our treatment of the links between HIV/AIDS and tuberculosis has been drafted in collaboration with the Working Group on Tuberculosis; broader consideration of the fight against tuberculosis is left to their report. Although we address the ways in which health systems will have to be strengthened to allow expansion of antiretroviral treatment, a more comprehensive analysis of health systems can be found in the report of the Task Force on Child Health and Maternal Health, which has made strengthening district-level health systems one of its central priorities. In addition, the health working groups are drafting a joint statement on health systems to reflect our shared conviction that strengthening these institutions will be the key to achieving all the health Millennium Development Goals. Finally, on general questions of development strategy, including poverty reduction strategies, the overall quantity and nature of development assistance, governance, and so on, we refer readers to the synthesis report of the UN Millennium Project as a whole: *Investing in Development: A Practical Plan to Achieve the Millennium Development Goals*.

In working to fulfill our broad mandate, we have relied in great part on the work of others. Our report draws from the vast body of existing research, as well as from our modest new analyses, some of which will be available as working group working papers, and the experience and judgment of working group members. We have sought to draw new attention to neglected issues, to redress what seem to us imbalances in current dogma, and to begin translating the high aspirations and idealism of the UN Millennium Project into practical action.

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Finally, Josh Ruxin and Paul Wilson acknowledge the support of the Center for Global Health and Economic Development at Columbia University, which provided a stimulating environment for carrying out this work.

Abbreviations

AIDS	acquired immunodeficiency syndrome
ART	antiretroviral therapy
CMH	Commission on Macroeconomics and Health
CCM	country coordinating mechanism
GDP	gross domestic product
HIV	human immunodeficiency virus
IMF	International Monetary Fund
INCB	International Narcotics Control Board
MAP	Multi-Country AIDS Program or Monitoring the AIDS Pandemic
MSF	Médecins Sans Frontières
NGO	nongovernmental organization
OECD	Organisation for Economic Co-operation and Development
PIH	Partners in Health
STI	sexually transmitted infection
TB	tuberculosis
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNGASS	United Nations General Assembly Special Session
USAID	United States Agency for International Development
UNICEF	United Nations Children’s Fund
UNODC	United Nations Office on Drugs and Crime
WHO	World Health Organization



Millennium Development Goals

Goal 1

**Eradicate
extreme poverty
and hunger**

Target 1.

Halve, between 1990 and 2015, the proportion of people whose income is less than \$1 a day

Target 2.

Halve, between 1990 and 2015, the proportion of people who suffer from hunger

Goal 2

**Achieve
universal primary
education**

Target 3.

Ensure that, by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary schooling

Goal 3

**Promote gender
equality and
empower women**

Target 4.

Eliminate gender disparity in primary and secondary education, preferably by 2005, and in all levels of education no later than 2015

Goal 4

**Reduce child
mortality**

Target 5.

Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate

Goal 5

**Improve
maternal health**

Target 6.

Reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio

Goal 6

**Combat
HIV/AIDS,
malaria, and
other diseases**

Target 7.

Have halted by 2015 and begun to reverse the spread of HIV/AIDS

Target 8.

Have halted by 2015 and begun to reverse the incidence of malaria and other major diseases

Goal 7**Ensure
environmental
sustainability****Target 9.**

Integrate the principles of sustainable development into country policies and programs and reverse the loss of environmental resources

Target 10.

Halve, by 2015, the proportion of people without sustainable access to safe drinking water and basic sanitation

Target 11.

Have achieved by 2020 a significant improvement in the lives of at least 100 million slum dwellers

Goal 8**Develop a global
partnership for
development****Target 12.**

Develop further an open, rule-based, predictable, nondiscriminatory trading and financial system (includes a commitment to good governance, development, and poverty reduction—both nationally and internationally)

Target 13.

Address the special needs of the Least Developed Countries (includes tariff- and quota-free access for Least Developed Countries' exports, enhanced program of debt relief for heavily indebted poor countries [HIPC] and cancellation of official bilateral debt, and more generous official development assistance for countries committed to poverty reduction)

Target 14.

Address the special needs of landlocked developing countries and small island developing states (through the Program of Action for the Sustainable Development of Small Island Developing States and 22nd General Assembly provisions)

Target 15.

Deal comprehensively with the debt problems of developing countries through national and international measures in order to make debt sustainable in the long term

Some of the indicators are monitored separately for the least developed countries, Africa, landlocked developing countries, and small island developing states

Target 16.

In cooperation with developing countries, develop and implement strategies for decent and productive work for youth

Target 17.

In cooperation with pharmaceutical companies, provide access to affordable essential drugs in developing countries

Target 18.

In cooperation with the private sector, make available the benefits of new technologies, especially information and communications technologies

Executive summary

AIDS is a global catastrophe, threatening social and economic stability in the most affected areas, while spreading relentlessly into new regions. In the past year, 3 million people died of AIDS, more than ever before and more than from any other infectious disease. Meanwhile, about 5 million more became infected with HIV. More than 39 million people carry the virus worldwide, 25 million of them in Sub-Saharan Africa. More than 2 million children are living with HIV, 15 million have been orphaned by the epidemic, and millions more have been made vulnerable by the illness of parents and family members. The suffering caused by AIDS has been compounded by the deadly synergy between HIV and tuberculosis. The spread of HIV has contributed to as much as a fourfold increase in the number of tuberculosis cases in parts of Africa. More than 10 million people worldwide are infected with both tuberculosis and HIV.

Despite local successes, national and international responses to the epidemic remain inadequate, whether judged by the limited reach of prevention and treatment programs or by their negligible impact on the course of the epidemic. For example, only 8 percent of those who need antiretroviral therapy in the developing world are receiving it (and only 4 percent in Sub-Saharan Africa); only 8 percent of pregnant women are offered services for preventing transmission to their infants; and even in the hardest-hit regions, most young people do not have reliable information on protecting themselves from infection. Moreover, the distribution of treatment and prevention services remains profoundly inequitable.

Yet the past few years have seen important breakthroughs. First, the epidemic is now firmly on the agenda of the United Nations system, development agencies, the World Bank, and many world leaders. The most significant manifestation of this increased visibility was the 2001 UN General Assembly

National HIV prevalence among adults ranges from a fraction of a percent to well over 30 percent

Special Session on HIV/AIDS (UNGASS). Second, resources for AIDS programs in the developing world have increased more than sixfold since 1996, with substantial new resources becoming available through the Global Fund to Fight AIDS, Tuberculosis and Malaria; the World Bank; and bilateral channels, including the U.S. government's large new initiative. There has been particularly strong commitment to funding expanded access to antiretroviral treatment. More resources will be necessary, but the central challenge is now to overcome the obstacles to scaling up prevention, treatment, and support for affected households, and thus to translate money and commitment into results on the ground.

Epidemic diversity

Global statistics cannot convey the growing diversity of the epidemic, which takes radically different forms in different communities, countries, and regions. National HIV prevalence among adults ranges from a fraction of a percent to well over 30 percent; the virus spreads through different populations by different means; and national capacity and willingness to respond vary enormously. Africa remains by far the most affected region, but there is no uniform "African epidemic." While Southern Africa faces stubbornly high prevalence and growing mortality, the epidemic may be waning in parts of East Africa, and in some other countries prevalence has remained low. Rates of infection are growing alarmingly in Russia and other parts of the former Soviet Union and in parts of India, China, and Southeast Asia. While the epidemic in these regions remains largely restricted to particularly vulnerable populations, there are some indications of spread into the general population. The older epidemics of Latin America and the Caribbean continue to evolve, but seem relatively stable. Some governments are increasingly confronting the challenge of AIDS head on, but others continue to deny its significance or even its existence within their borders.

These increasing differences among countries and regions need to be more broadly appreciated and taken into account at the international level by donors, advocates, and journalists. At the local level, policymakers must be guided by the best possible information on local conditions, while at the same time incorporating the lessons learned from neighboring countries and other regions.

For the purposes of this report, we will often make use of a simple dichotomy that captures several important features of many national epidemics. On one hand are the most affected countries, almost all in Sub-Saharan Africa and almost all very poor. There, prevalence is high, transmission is primarily by heterosexual intercourse, and the epidemic is well established in the general population. In this context the fundamental challenges to reversing the epidemic are lack of resources, weak health systems, and the barriers to widespread behavior change posed by poverty and gender inequality. On the other hand are many countries of Eastern Europe, Asia, and Latin America, with

The outcome goals and the coverage targets provide clear benchmarks

lower prevalence epidemics concentrated in key populations, such as injecting drug users, sex workers, and men who have sex with men. In these countries, the greatest obstacles to containing AIDS are denial, lack of political will, and misguided, punitive policies toward those most affected by the epidemic.

This basic distinction is a recurring theme of our report. Perhaps inevitably, our report focuses in large part on the high-prevalence African epidemics, but several of our most important recommendations apply with particular force to those countries with concentrated epidemics.

The Millennium Development Goals and the UN Millennium Project

The Millennium Development Goals represent an unprecedented global commitment to combating poverty, hunger, disease, and inequality. Goal 6, “to combat HIV/AIDS, malaria, and other diseases,” elevates the fight against AIDS to a place among the world’s highest development priorities, recognizing the enormous suffering the epidemic causes, as well as the threat it poses to achievement of the other goals.

The Working Group on HIV/AIDS of the UN Millennium Project Task Force on HIV/AIDS, Malaria, TB, and Access to Essential Medicines has been asked to outline how this goal and the accompanying target, “to have halted and begun to reverse the spread of HIV/AIDS by 2015,” can be met. In working to fulfill this broad mandate while avoiding unnecessary duplication, we have relied in great part on the work of others. Our report is drawn from the vast body of existing research, as well as from our modest new analyses and the experience and judgment of working group members. We have sought to draw new attention to neglected issues, to redress what seem to us imbalances in current dogma, and to begin translating the high aspirations and idealism embodied in the Millennium Development Goals into recommendations for practical action.

Interpreting the AIDS Goal

The Millennium Development Goal for AIDS and its target lack the quantitative benchmarks that make some of the other goals verifiable commitments. To give the AIDS goal a rigorous interpretation, the working group proposes two demanding but attainable targets for 2015:

- Reduce prevalence among young people to 5 percent in the most affected countries and by 50 percent elsewhere by 2015.
- Ensure equitable and sustainable access to antiretroviral therapy to at least 75 percent of those in need by 2015.

To motivate specific action, we supplement the overall goals with coverage targets for key prevention and treatment interventions. Together, the outcome goals and the coverage targets provide clear benchmarks for measuring both overall progress and concrete action.

**Treatment
can assist
prevention
in important
ways, but
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not bring the
epidemic
under control**

The working group recognizes that it might be possible to reduce HIV prevalence and bring treatment to many without reaching the poorest and most vulnerable populations, or by sacrificing progress in other areas, such as maternal and child health. This would not be acceptable. Our report stresses two basic requirements for ensuring equitable access to AIDS services, especially antiretroviral treatment. First, the poor will be left out—and other health priorities jeopardized—unless the health systems that serve them are strengthened. Second, women, children, and marginalized populations, such as injecting drug users, may be excluded if their right to prevention and care services is not vigorously defended.

Ten imperatives

We have organized our most important findings into 10 basic imperatives that, if followed, should ensure that the world meets the Millennium Development Goal for AIDS.

Reinvigorate prevention

As the UNGASS Declaration of Commitment stated, prevention must be the mainstay of the response to the epidemic, as only by preventing new infections can the epidemic eventually be brought under control. The long-overdue drive to expand treatment—energized by the WHO/UNAIDS initiative to provide antiretroviral therapy to 3 million people by 2005 (“3 by 5”) and large influxes of funds—has mobilized activists, national governments, and the United Nations system, and now dominates the AIDS agenda at all levels. Every effort must now be made to bring the same sense of urgency and excitement to meeting ambitious prevention goals. Unless prevention remains a fundamental priority of leaders, donors, and those who battle the epidemic on the ground, tens of millions more will become infected and the need for treatment will grow inexorably. As is now widely recognized, treatment can assist prevention in important ways (see below), but treatment alone will not bring the epidemic under control.

Effective prevention requires a combination of interventions, providing tools to block the various routes of infection as well as enabling those at risk to make use of these tools. Much has been learned about what works in prevention, and the working group endorses a standard list of interventions. These include:

- Education and behavior change campaigns for youth and the general population.
- Harm reduction, behavior change, and condom promotion programs focused on vulnerable populations.
- Voluntary testing and counseling.
- Control of sexually transmitted infections.
- Prenatal testing and antiretroviral drugs to prevent mother-to-child transmission.

Where epidemics are highly concentrated, programs for the general population must not substitute for services for those most in need

- Health system precautions and blood safety.

Although the effectiveness of each of these interventions has been demonstrated, most reach only a fraction of those who could benefit from them. These proven measures must be scaled up rapidly; this will require increased resources and renewed commitment to comprehensive prevention. But reaping the benefits of these prevention measures will also require overcoming the structural barriers to their widespread adoption, in particular profound gender inequities and the political and legal obstacles to reaching critical high-risk populations with effective services (see below).

As HIV prevention programs are scaled up, links should be strengthened to the broader set of reproductive health services, including family planning and safe motherhood. Although reproductive health and HIV programs share many goals and have much to teach one another, these ties have generally been weak.

Although the technologies we have in hand can avert millions of infections, prevention efforts would be greatly strengthened by new and improved tools. Research on microbicides and other female-controlled methods must be a particularly high priority. Although an effective vaccine is unlikely to be available in time to help in meeting the Millennium Development Goals, the potential impact of a vaccine justifies a sustained, long-term commitment to research and development even in the face of setbacks. Social science and operational research leading to more effective use of existing prevention tools is just as important. Improved monitoring and evaluation is also essential: without better information on the epidemic and on the effectiveness of programs, decisions will continue to be made in the dark.

Focus on vulnerable populations

Although all of these elements of prevention are important, clear priorities reflecting local circumstances are essential, even when resources are not immediately limiting. Failure to set appropriate prevention priorities can be a political choice: the most important programs are sometimes willfully neglected in the name of the rest. In particular, the working group reiterates the fundamental importance of focusing prevention efforts on populations most at risk, especially in concentrated epidemics. Few elements of HIV prevention doctrine rest on as solid an empirical and theoretical foundation. We believe that the single highest priority in Russia, Ukraine, much of China and Southeast Asia, as well as in large parts of India and Latin America, should be needle exchange and opiate substitution services for injecting drug users, who bear the greatest burden of new infections in these areas. Similarly, information, condoms, and health services for sex workers and men who have sex with men must be a central priority where these groups are at particularly high risk. We stress that governments have a responsibility to ensure that all people, even those at low risk, receive basic information about HIV and how to protect themselves. But

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where epidemics are highly concentrated, programs for the general population must not be allowed to substitute for services for those most in need.

Bringing effective prevention to drug users is not primarily a matter of resources and technical capacity, although these are of course important, but a question of policy and political will. Success requires adopting evidence-based public health approaches to drug use and its consequences instead of the failed criminal enforcement strategies employed today by almost all governments where injecting drug use is fueling the spread of HIV. The working group urges national governments to stop exacerbating the epidemic by criminalizing and imprisoning drug users and to provide instead proven harm-reduction services, including needle and syringe exchange and drug-substitution treatment. To help achieve this end, moreover, the UN system must speak with a single voice against punitive approaches, affirming clearly that harm reduction is both good policy and fully consistent with international drug control treaties. The UN and some national governments have taken promising steps in the past year, but it remains to be seen whether official statements will translate into changes on the ground.

Other vulnerable populations also suffer from discriminatory laws and ill-conceived punitive approaches: policies that drive sex workers and men who have sex with men underground and away from prevention and care services are counterproductive and should be abandoned.

In high-prevalence, generalized epidemics, the greatest prevention priority must be to bring about widespread behavior change by promoting open discussion of HIV, gender, and sexuality; stimulating and supporting community mobilization; and combating stigma and gender inequality. Programs must be designed to reach young people and accommodate their distinct needs. Even where prevalence in the general population is high, however, prevention campaigns must focus special attention on those whose circumstances or behavior puts them at higher risk of contracting or transmitting HIV.

Ensure equitable access to treatment

The working group believes that treatment and care must stand alongside prevention as essential elements of a comprehensive response to the epidemic. Only treatment can prolong the lives of the 39 million people who already carry HIV and, in the highest prevalence countries, forestall continued catastrophic rates of illness and death and the attendant social and economic devastation. Moreover, the current situation, in which access to life-saving treatment is primarily determined by ability to pay or country of residence, is fundamentally unjust.

After years of delay, a growing number of governments, donors, and international organizations are at last committed to rapidly scaling up antiretroviral therapy. We endorse the WHO/UNAIDS 3 by 5 initiative, which aims to provide antiretroviral therapy to 3 million people by the end of 2005, and

The greatest barrier to widespread access to treatment is the deplorable state of health systems

propose a target of reaching 75 percent of those in need by 2015. Our report focuses less on making the case for expanding treatment—we consider this battle to be largely won—and more on how to overcome the considerable challenges to bringing treatment to those who need it in the poorest countries.

The working group believes that the greatest barrier to meeting the goal of widespread access to treatment is the deplorable state of health systems in most of the hardest-hit countries. Poverty, misplaced priorities, and years of externally imposed restrictions on social spending have left health services for over 2 billion people dysfunctional, inaccessible, or priced beyond the reach of the poor. The greatest challenge in the most affected countries is an acute shortage of skilled healthcare workers.

As remedying this situation will take time, treatment programs must be designed to make optimal use of existing staff. Nurses, clinical officers, and other personnel must assume roles assigned to doctors in the rich countries. Appropriately trained lay people must help provide counseling, adherence support, and other vital services now handled by healthcare personnel. Clinical protocols and drug regimens must be simplified to the greatest extent possible. Communities, and especially people living with HIV, must be involved in decisionmaking and must contribute to treatment delivery itself. In fact, if treatment programs are to succeed, they must build strong ties to communities and to community AIDS initiatives in prevention, home-based care, and orphan support.

In some countries, notably those that have received large grants from the Global Fund, the U.S. government, or other sources, the cost of antiretroviral drugs is no longer the primary obstacle to expansion of treatment programs. In the longer run, however, the sustainability of antiretroviral therapy in the developing world will require bringing prices down further. Cheaper and more convenient second-line regimens, drug formulations for infants and children, and diagnostics are particularly urgent priorities. More research is also needed into the most efficient and effective ways to deliver treatment and ensure adherence where clinical staff are scarce and health infrastructure is weak.

Invest in health systems as AIDS services are expanded

Even with the most creative delivery strategies, it will be impossible to bring antiretroviral treatment to all who need it in the poorest countries without strengthening health systems and recruiting and training many new health workers. Critical prevention measures, including the treatment of sexually transmitted infections and services to prevent mother-to-child transmission, also depend on functioning health systems. Moreover, the health Millennium Development Goals as a whole, and more generally the elusive goal of bringing basic health services to all, will never be met without vigorous financial and political commitment to health systems. Since it will take years to expand

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the pool of skilled health-care workers, investments in training capacity, along with other critical elements of health systems, must begin now. Thus countries must build for the future as they urgently expand access to treatment and other services in the short run.

The working group recommends that a significant share of new treatment resources be devoted to investments that benefit health systems generally. Moreover, treatment should be integrated whenever possible into existing structures of care rather than delivered through stand-alone systems. These measures will ensure that progress toward the goal of universal treatment access is sustainable and that gains against AIDS are not achieved at the expense of other health priorities, including combating malaria and tuberculosis and improving maternal and child health.

The deadly interactions between HIV and tuberculosis make strong links between HIV and tuberculosis programs particularly important. In addition to joint planning and greater communication at all levels, several specific steps should be taken, including offering HIV testing and counselling to tuberculosis patients and providing treatment to coinfecting individuals.

Investing in health systems is also essential to ensuring equity in AIDS treatment in the most affected countries. Where many do not have access to even basic healthcare, antiretroviral therapy will benefit the better off first. While expansion of treatment cannot wait for health systems to be fully built, access will remain inequitable if scaling up is not accompanied by steps to strengthen basic services for the poor.

In many of the countries facing concentrated HIV epidemics, by contrast, the key to treatment equity is guaranteeing access to vulnerable populations: injecting drug users, sex workers, men who have sex with men, and ethnic minorities. In Russia, China, Viet Nam, and many other places, it will be very important to ensure that access to treatment is not denied to the very groups who need it most. The working group urges countries to develop systems for monitoring access to antiretroviral therapy among these critical populations, as well as among women and among children under age 15.

Integrate prevention and treatment

The working group shares the current enthusiasm for integrating prevention and treatment. We call for the incorporation of concrete prevention elements into treatment plans now being developed in many countries. Much will have to be learned by experience, but the essential elements of integration should include:

- Rapidly expanding HIV testing, including traditional voluntary counselling and testing as well as routine offer of testing in appropriate clinical settings, with strong links to prevention services, treatment, and care.
- Incorporating prevention counseling, referral to reproductive health services, and other prevention measures into clinical settings.

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- Ensuring that diagnosis and treatment of sexually transmitted infections are available wherever HIV care is provided.
- Harmonizing prevention and treatment messages, both in the community and through other channels, to ensure that treatment reinforces prevention rather than undermining it. It will also be important to carefully monitor attitudes and behavior as treatment is scaled up to allow prevention messages to be modified quickly if behavior changes.

The advent of treatment in the developing world represents an enormous opportunity for prevention, but fulfilling this promise will require influencing the design of treatment programs and devoting real resources to incorporating vigorous prevention elements. As the experience of the developed world shows, access to treatment will not bring down the rate of new infections by itself.

Address root causes: empower women and girls

Prevention and care programs will fail if they ignore the underlying determinants of the epidemic: poverty, gender inequality, and social dislocation. At a minimum AIDS programs must take these sources of social vulnerability into account; in the longer run they must be tied to efforts to reduce them. The relative powerlessness of women and girls, together with pervasive gender attitudes and practices, contribute particularly strongly to the spread of HIV. Much can be done now to ensure that AIDS programs recognize the special vulnerability of women and girls. But the most powerful answers to the problem of women's vulnerability will be those that transcend AIDS: promoting girls' primary and secondary education, guaranteeing equal property rights and economic opportunity, and combating violence against women.

Plan for orphans and vulnerable children

UNICEF estimates that more than 12 million children in Sub-Saharan Africa have lost one or both parents to AIDS; this number is projected to grow to 18 million by 2010. An equal or greater number of children have been made vulnerable by the epidemic in other ways—by the illness of parents or other family members or by living in a household struggling to care for many orphans. This enormous tragedy has received far too little attention. Countries must develop national strategies for assisting families and communities to care for orphans, ensuring that they are able to attend school, protecting them from exploitation, and enforcing their rights to property. Donor nations and international organizations must provide greatly expanded resources and technical assistance.

It is important to recognize that even in Sub-Saharan Africa the majority of orphans have lost their parents to causes other than AIDS, although in the hardest-hit countries of Southern Africa the epidemic is greatly increasing the burden on families and communities. In most circumstances it is neither just nor practical to target services specifically to children affected by AIDS.

The poorest countries cannot defeat AIDS without much greater help from the international community

Instead, communities should be involved in determining which children and which households are in greatest need. At the national and international levels, the attention and resources that the AIDS crisis is finally bringing to the needs of orphans should be used to spur progress toward the goal of supporting *all* vulnerable children.

Require more from the United Nations

The United Nations, with its established presence in almost every country and its broad legitimacy, is uniquely placed to play a central role in the fight against the global epidemic. Through UNAIDS and its cosponsors, the UN system has made important contributions at the global level, placing AIDS at the top of the international agenda and building international consensus around basic elements of a comprehensive response. The working group believes the UN could do more, particularly in two areas. First, it should be far bolder in holding accountable member nations that have failed to honor their commitments to fighting AIDS. The UN should draw attention to the failures in leadership, misguided policies, and gaps in financing that continue to stymie an effective response.

Second, the UN is not doing enough to help countries meet their objectives. It must focus on providing more useful and appropriate technical and management assistance; in many countries, its record in these areas has been poor. The fundamental problem has been insufficient, and in some cases inadequate, personnel on the ground. In many of the hardest-hit countries, UN staffing falls far short of what would be required to help governments do what is necessary. Remedying this shortcoming will require substantial new resources.

More broadly, the UN Millennium Project as a whole is calling for UN country teams to assume a greater role in assisting countries to plan for achieving the Millennium Development Goals. The project recognizes the constraints and institutional deficiencies that will make this a daunting challenge for the UN. But there simply is no other institution, or set of institutions, that can play this role.

Expand international and domestic financing and remove barriers to its use

International financing for AIDS and, more broadly, for building the health systems needed to combat the epidemic remains insufficient. Although there is wide consensus that a comprehensive response to the epidemic would require at least \$10 billion per year, UNAIDS estimates that only \$6 billion was spent in 2004. The Global Fund to Fight AIDS, Tuberculosis, and Malaria was created in 2001 to begin filling the gap between country needs and funds available from traditional bilateral and multilateral sources. Despite significant successes and widespread enthusiasm among its recipients, the Global Fund lacks the resources to fulfill its commitments. At least \$2.3 billion in additional funds will be needed in 2005 alone. Moreover,

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donor aid in general must be more predictable and free of conditions that reduce efficiency and distort policy.

While the poorest countries cannot defeat AIDS without much greater help from the international community, they can demonstrate commitment by increasing national spending on AIDS and health systems, creating a true partnership with donors.

In many developing countries, restrictions on public sector spending and hiring are a major obstacle to making use of new resources in the fight against AIDS. The International Monetary Fund and other international financial institutions should work with national governments and donors to find creative ways to reconcile substantial increases in spending on health and other social services with macroeconomic stability.

Empower governments and hold them accountable

An increasing number of national and international organizations—bilateral donors and their contractors, UN agencies, international and local nongovernmental organizations, foundations, the private sector, government ministries, national AIDS coordinating bodies—are involved in delivering, funding, or overseeing AIDS services. Better coordination at all levels will be essential to a more effective response and will depend on establishing clear roles and responsibilities.

It is particularly important that ministries of health and national AIDS councils or commissions end confusion over the division of responsibilities between them. National ownership and control should be an overriding principle: donors and international organizations must ensure that their work contributes to national priorities and national plans as defined by governments, working with other stakeholders. Furthermore, where well-developed government strategies are in place, donors should move toward broad and flexible financing of government programs, including capacity-building and salary support. As a first step, the working group endorses UNAIDS' call for "three ones" at the country level: one AIDS action framework, one national AIDS coordinating body, and one monitoring and evaluation system.

In many of the hardest-hit countries, as well as those threatened by growing epidemics—India, China, Russia—AIDS still does not receive sufficient attention and resources from national leaders and governments. The UN, as well as the Bretton Woods institutions and donors, must demand that these countries take the threat of AIDS seriously and back words with budgetary commitments. National governments should be required to demonstrate how they plan to combat the epidemic, who will be responsible, and how progress will be measured.

Conclusion

We now have in hand a range of proven, effective ways to control the spread of HIV and to prolong the lives of those who are already infected. The working

group believes that scaling up these established interventions could save millions of lives and bring the epidemic under control. But success will depend critically on how this is done. First, prevention and treatment must be scaled up together: just as for years life-saving treatment was considered too difficult or too expensive for the developing world, there is now a danger that prevention will be overlooked. Second, expansion of AIDS services must be accompanied by sustained investment in health systems, especially in human resources, and programs must be structured to minimize destructive competition for skilled staff and other scarce resources. Third, programs must be designed and policies put in place to ensure that prevention and treatment services reach the poor and the vulnerable populations who need them most. Success will require greatly increased resources from donor nations, as well as stronger commitment from many governments in affected countries.