HIV/AIDS Today: Continuing and Emerging Challenges

An epidemic in transition

Much has changed in the 24 years since the first HIV infection was documented. The epidemic has evolved differently across regions, and our ability to track and understand it has grown markedly. While the epidemic is ever-evolving, in most of the world HIV infections remain at low levels, largely concentrated among sub-populations: injecting drug users (IDU), sex workers (SW), and men who have sex with men (MSM). In most countries, therefore, preventing new infections in these subgroups and their sexual partners through reducing risk needs to be the main focus.

The epidemic varies across and within regions, with some countries more affected than others. In Latin America and the Caribbean, for example, 11 countries have an estimated national HIV prevalence of one percent or more, while the rest of the region has much lower general prevalence. Within countries, there are often wide variations among subgroups and geographic areas. Some of the most heavily populated countries in the world (e.g., China and India) currently report an overall prevalence of less than one percent, yet the infection rate is much higher—and rapidly rising—among a number of high-risk subpopulations. For example, in Chennai, India, HIV prevalence among drug injectors rose from 26 percent in 2000 to 64 percent in 2003. HIV among sex workers in Myanmar rose from around 5 percent in 1992 to 31 percent in 2003, and from 1.7 percent in 2000 to 9 percent in 2004 among 70 sex workers in Tamanrasset, Algeria. Prevalence in a random sample of inmates in a West Java prison went from one percent in 1999 to 21 percent in 2001 and 2003.[1]

There are regions, such as the Middle East and North Africa (MNA), where the pattern, level and spread of the epidemic is not well understood due to limited surveillance and behavioral risk data.

The diversity of the AIDS epidemic across and within regions and countries poses challenges

In some countries—largely in Southern and Eastern Africa and in parts of the Caribbean—the epidemic has spread widely into the general population, with adult prevalence over two percent in the Caribbean and over seven percent in Sub-Saharan Africa as a whole. A range of strategies is required to prevent new infections, ensure care and treatment for all those affected, mitigate the sweeping impact, and support sustained programs. With so many people infected in these countries and increasing priority being given to treatment, efforts to prevent new infections still must be sustained and enhanced. Even in countries with the highest prevalence, the majority of the population is not infected, and adults and new generations of young people need to be able to protect themselves from the risk of infection.

The tremendous diversity across and within regions and countries poses its own set of challenges: the need for good surveillance, to understand the specific transmission dynamics in each context or country in order to design effective interventions; the need to ensure that interventions reach target groups in concentrated or low-level epidemics; the need for a comprehensive approach in generalized epidemics; the overarching need for strong political commitment and broad social mobilization to end stigma, silence and denial no matter what the epidemic stage, and to change the cultural norms, beliefs, roles, and practices in which sexual behavior is deeply rooted.

The possibility of widespread treatment has transformed the epidemic but access remains very limited

There have been successful prevention programs, but they have rarely been of sufficient scale or implemented widely around the world. We now have extensive experience with prevention and, more recently, with treatment and mitigation programs, and we learn new lessons every day. It is more difficult to target individuals with risky behaviours when they are subject to social taboos, or are marginalised, or not clearly identified—for example, widely dispersed informal and part time sex workers who do not work in establishments or "red-light" districts, injecting drug users, highly sexually active men, and most of the MSM who do not identify themselves as gay. Prevention campaigns may have to address the entire population to reach those at most risk. Reaching people at highest risk of infection is also more complex, and less epidemiologically effective, in a generalized epidemic than in a concentrated one.

The possibility of widespread treatment has transformed the epidemic, extending the years of healthy life of people who have access to effective and affordable antiretroviral therapy. Access remains very limited, however, representing a missed opportunity to save lives and safeguard development. Greater access to treatment would give years of healthy life to people with scarce needed skills and expertise, and keep parents alive and well to care for their children, who would otherwise join the millions of children orphaned by AIDS. So the challenges in highly-affected countries are more varied: to build local capacity to manage a long-term, chronic disease; to ensure long-term maintenance of safer behaviors; to provide long-term support to survivors; and to plan for cohorts of young people who may begin risky behaviors in the future.

Young people are increasingly at the center of the HIV/AIDS epidemic. More than half of those newly infected with HIV are aged 15-24, and there are more than 12 million young people now living with HIV/AIDS. But young people also represent the future and biggest hope in fighting the epidemic.[2] Nearly all school age children are free of HIV infection, even in the worst affected countries, and if they remain uninfected as they grow up, they could change the face of the epidemic within a generation. Promoting positive and safe behaviours must start before young people become sexually active or begin to use drugs.

Many adolescents are sexually active and engage in unprotected sex, and adolescence is also the time when drug use often begins. This is a critical age to provide appropriate information, education and communication (IEC) interventions.[3] Yet many young people do not have the knowledge or means to protect themselves from HIV/AIDS. For example, even in countries with generalized epidemics such as Cameroon, Central African Republic and Lesotho, over 80 percent of young women have insufficient knowledge of HIV/AIDS.

To prevent infections, young people need youth-friendly and gender-specific information, health services and counselling and access to condoms. Providing HIV/AIDS prevention in schools is critical but programs must also reach youth living in the streets, and those involved in commercial sex work or injecting drug use. Including young people in the design and implementation of programs is an effective way to reach and relate to their peers.

As the epidemic and the worldwide response to it continue to evolve, new challenges and new obstacles are emerging. Identifying these challenges and devising appropriate responses must be part of any effort going forward.

Unresolved longer-standing challenges also remain, for which solutions are increasingly understood. The refrain—"We know what works!"—may be an exaggeration in some cases, but in many others it is not. Our knowledge is incomplete, but it is substantial. The task with these recurring challenges is not so much to figure out what needs to be done but to figure out how to do it.

As background to this Program of Action, an overview of the continuing and emerging challenges is presented below. This is not a list of problems the Bank intends to fix; it is, rather, a list of realities that the Bank, other major donors, and countries need to be aware of in planning HIV/AIDS strategies in the new millennium.

Continuing challenges

If we really have learned so much about HIV over the last two decades, then why is the epidemic still growing? Why will more people be infected with HIV and die of AIDS in 2005 than in any previous year? In short, why aren't we applying what we know?

We *are* applying some of it, of course, although not systematically nor on a scale commensurate with the need, and it is certainly true that we have a great deal more to learn. But there are major obstacles that stand in the way of doing what works.

Limited strategic planning

By and large, efforts against AIDS are not coordinated well at the national level and are not part of an overall strategic plan. There are many plans, no plans, or different plans in different sectors; some efforts duplicate others, some address problems that are not priorities (see box on Strategic Planning), and some problems are ignored altogether. HIV/AIDS

Many national plans do not strategically target the main ways HIV is transmitted

Looking for the "strategic" in strategic planning

Many countries have developed national plans, often through extensive consultation with stakeholders. These plans have helped to elevate national commitment, foster engagement and promote social openness about HIV/AIDS. But they have often not been truly strategic; that is, they have not identified and targeted the primary ways HIV is transmitted in a given country.

One country in Africa prepared a consultative and strategic plan which presupposed a highly generalized epidemic and emphasized the widest possible engagement of society and a broad range of interventions. HIV prevalence in the country's general adult population is 1.8 percent and antenatal data indicate that the epidemic has been stable for approximately a decade. The data also suggest that the peak age of HIV infection is relatively high, between 35-39 years, for men and women. In contrast to relatively low rates in the general adult population and among youth in the country, HIV prevalence among sex workers is exceptionally high—78 percent and 82 percent in the two largest cities. The great difference between rates among sex workers and the general adult population suggests that a significant proportion of infections in this country arise from commercial sex. A recent study estimated that 75 percent of infections among sexually active men in the capital were acquired from sex workers. Yet a recent review indicated that only 0.8 percent of this country's HIV/AIDS investments were aimed at sex work interventions.

This is not an isolated phenomenon. In one Asian country, HIV infection in the general population remains low, at under 0.3 percent of pregnant women for example. In contrast, rates among injecting drug users approach 80 percent in the largest city, and rates of 30 percent have been reported among sex workers in selected sites. This country is clearly experiencing a concentrated epidemic, with exceptional vulnerability among marginalized populations. Epidemiological analyses indicate that injecting drug use contributes perhaps three-quarters of HIV infections, and injecting drug use and sex work together account for more than 90 percent. Despite these data, interventions to protect these two vulnerable groups are just one of this country's nine major strategic priorities.

In one Latin American country, the epidemic is largely concentrated among men who have sex with men. A study of over 7,500 such men between 1991 and 1997 found that more than 15 percent were HIV-positive, against an overall adult prevalence of 0.3 percent. Given the likelihood that bisexual men are one route by which AIDS enters the heterosexual community, low condom use among this population is worrisome. In the survey cited above, 85 percent of bisexual men in this country never used condoms during anal sex with their female partners, and 69 percent never used them during vaginal intercourse. Yet the majority of HIV prevention funds in the country are directed towards the "general population" and less than 10 percent are targeted towards men who have sex with men.

HIV/AIDS makes especially strong demands on health systems, which must be strengthened

and its financing are often not integrated into overall development and financial planning.

There are a number of reasons why countries do not plan more strategically or, if they do, why they do not always follow these plans:

- Missing data, especially on risky behaviors, on the patterns and drivers of infection, on program effectiveness and on economic and social impact.
- Inadequate mechanisms to analyze and use data (when they are available), especially for prioritizing HIV/AIDS investments.
- Reluctance to prioritize, because of the difficult choices that must be made.
- Limited capacity to conduct regular planning that involves many sectors of government and society, in particular to help each sector assess realistically its comparative advantage in responding to HIV/AIDS.
- Limited ability of governments to plan a national response when significant external resources are channeled directly to non-government entities with limited consultation, and external resource flows are unpredictable or uncertain.
- Competition among stakeholders, in both the public sector and civil society, due to unclear roles and responsibilities and lack of ownership.
- Persistent knowledge gaps in some key areas, such as effective prevention strategies and how to scale up service delivery.

Management and implementation constraints

Even well-planned programs will have limited results if they are not well managed and implemented. In many countries there is insufficient support for implementation, especially for scaling up programs in both the public sector and civil society. And where there has been support, programs rarely benefit from lessons learned in other parts of the country or from other countries. Many countries, especially those hardest hit by HIV, and implementing agencies within countries face obstacles to successfully managing and implementing their programs:

- The tendency of management entities to "control" resources rather than to pass them on to and "empower" those who actually carry out programs.
- Systems of fiduciary accountability—financial management and disbursement and procurement of goods and services in particular—that are more burdensome than relevant and do not take local conditions into account.
- Implementation units with insufficient resources, skilled personnel, and regional and international knowledge about what works, especially with regard to the challenges of scaling up HIV prevention, care and treatment, and mitigation programs.
- The reluctance of many in the public sector to contract program implementation and administration to existing civil society and private sector agencies in the country.
- Unnecessary duplication of management and monitoring and evaluation systems to meet the requirements of different donors.
- Unpredictable, erratic, or narrowly targeted disbursements of donor funding, often outside of national budgetary planning processes and cycles.

Weak and overburdened health systems[4]

While the causes and consequences of HIV affect many sectors, it makes especially strong demands on the health sector, which has a central role in surveillance, prevention, diagnosis and treatment of HIV/AIDS and of opportunistic infections. Despite efforts over the years to improve health systems, they remain very weak in many countries, including some that are the worst affected by HIV/AIDS. Health systems *must* be strengthened—to fight HIV/AIDS and to address numerous other diseases and health problems. With the caveat that there are significant variations across and within countries, the major obstacles to effective health system responses to HIV/AIDS, and, more broadly, to improved health outcomes and sustainability, include:

- Not enough investment in health systems. Donor and government efforts to improve health systems generally—and human resources, provision of pharmaceuticals and surveillance and other core public health functions specifically—have been inadequate.[5] Nor has adequate at-

tention been paid to the coherence of investments in health systems and their medium- to long-term sustainability.

- Inadequate understanding of what works in health system development, and under-appreciation of the complexity of health systems and service delivery. The record of external efforts to support health sector strengthening is mixed. While there is evidence of improved capacity for program planning and local leadership in some contexts, these often do not translate into improved performance.
- To some extent, global initiatives may sometimes supplant rather than support country-led strategies and work plans in health. The High-Level Forum (HLF) on the health MDGs is discussing approaches to harmonizing and coordinating investments in health systems at the country and global levels.[6] The proliferation of initiatives on AIDS and other diseases has brought additional financing, primarily for disease control efforts. Donor support for building the capacity of health systems has not kept pace with increasing demands to scale up the delivery of services. The HLF Working Group has identified an urgent need for clear, coherent guidance on how health initiatives can contribute to improving health systems components.
- Inadequate numbers, skills and distribution of health workers, due to weak incentives, shortages of training facilities, brain drain and losses of health sector workers to AIDS (see box on "People", p18).
- Inequities in access to and utilization of health services.[7]
- Restrictions on the use of some development assistance funds for recurrent costs, including salaries. ARV drug costs have declined, but other costs associated with treatment—e. g., medical and support personnel, non-ARV drugs, biological monitoring—have remained constant. Many donors traditionally have been unwilling to pay for these "local operating costs".
- Emphasis by donors on reaching many people with ARVs, without adequate attention to the quality of care and to sustainability, given that ARV treatment is a lifelong commitment.
- Resistance among public sector staff to expanding the role of the private sector and civil society to deliver services.

Limited reach of prevention, care and treatment services

The sense of emergency that has characterized much of the response to HIV has combined with the natural inclinations of many funding organizations to produce an explosion of pilot projects and other small-scale activities. Large-scale, long-term sustained interventions, underpinned by reinforcing developmental investments and actions are what are needed now. Efforts to expand care, treatment and prevention programs have been frustrated by a number of obstacles:

Large-scale, long-term sustained care, treatment and prevention programs are needed

- HIV programs, particularly prevention efforts, have often focused on changing the behavior of a small group of individuals rather than on designing comprehensive or structural approaches to an entire at-risk group.
- Without clear HIV/AIDS communications strategies, messages have not always been consistent or effective.
- Too little effort and resources have been invested in HIV prevention. As access to treatment expands, care should be taken that prevention is not neglected, which will result in an unsustainable growth in demand for treatment.
- The effort to make treatment widely available to the millions who need it, needs to be intensified, along with building the required infrastructure to make access possible.
- Stigma and denial deter people from coming forward and prevent programs from reaching many infected people, notably men who have sex with men, injecting drug users, and sex workers.
- The staff available to deliver programs on a large scale is limited, especially in countries where those most in need of services are widely dispersed, highly mobile, in rural areas or concealed.
- Many governments are reluctant to contract program management and service delivery outside the public sector, even where this would increase coverage, efficiency, and quality—and significantly close the implementation gap.

People: A key factor in the resource equation

With new resources available for large-scale treatment, countries affected by AIDS confront a critical shortage of health workers, and expertise, including in epidemiology, virology, designing and managing prevention and treatment programs, and monitoring and evaluation. The severity and types of human resource constraints vary across countries. Africa has a quarter of the world's disease burden but only one percent of its health workers.[1] Even if vacant posts could be filled, staffing levels still would not be adequate to meet the rising demand for care.

The shortage of health workers has many causes.[2] Too few health workers are trained, too many die or move abroad, those in post are maldistributed relative to needs. Forty percent of the new graduate nurses in Zambia and Malawi each year are needed just to replace nurses who die – many of AIDS. There are more Malawian nurses in Manchester, England than in all of Malawi. Tanzania has 26 times more nurses per capita in Dar es Salaam than in some rural areas. Weak public sector management and poor incentives and working environments erode productivity, and donors contribute by luring senior managers away from the public sector. Kenya's civil service payroll was estimated to include 5,000 "ghost" health workers. Doctors in many developing countries earn as little as $50 per month. Low salaries sap morale and force health workers to undertake multiple jobs or activities.

Needs and solutions vary, but these options could help in many countries: Some countries have under-employed doctors and nurses, and other unemployed university graduates who, with appropriate training and supervision, could be deployed to meet shortfalls in program planning and management. More training schools are needed, and rapid courses to train intermediate level para-professionals who can later upgrade their skills. Contracting private sector suppliers may help, but nursing agencies are rare in Africa. Better salaries need to be arranged, and better working conditions and career development prospects are also needed. Staff could be distributed better, with incentives for rural service. Better public sector management is needed, combined in some cases with decentralization. All these are to be considered within a framework of sustainable financing.

1. High Level Forum on the Health MDGs, "Addressing Africa's Health Workforce Crisis: an Avenue for Action", Paper prepared for the meeting in Abuja, in December 2004. Accessed online on 06/03/05 at: http://www.hlfhealthmdgs.org/Documents/AfricasWorkforce-Final.pdf
2. High Level Forum on the Health MDGs, "Health Workforce Challenges: Lessons from Country Experiences", Paper prepared for the meeting in Abuja, in December 2004. Accessed online on 06/03/05 at: http://www.hlfhealthmdgs.org/Documents/HealthWorkforceChallenges-Final.pdf

Stigma, discrimination, laws and social norms can undermine HIV/AIDS prevention, care and treatment

- There is still not enough money for salaries and operating costs and for some services, especially if the service is expensive (such as treatment) or politically unpopular (such as services for injecting drug users or sexual health services for adolescent girls).

Social and political factors

Social and political circumstances and laws can greatly influence the success of HIV prevention, care and treatment services. Where people may be persecuted, for example, or subjected to stigma and discrimination because of HIV/AIDS, they are less likely to seek out prevention, testing, and treatment services. If use of preventive methods such as condoms or clean injecting equipment is discouraged, prevention programs are weakened. Approaches that violate the rights of people in need of services have also been shown to be counter-productive. Some social gender norms make girls and women more vulnerable and have resulted in women and girls now being the most affected by the epidemic (see Box on Feminization of the HIV/AIDS Epidemic). Progress in changing social and political obstacles has been inhibited by:

Feminization of the HIV/AIDS epidemic

The HIV/AIDS epidemic is increasingly affecting women and young girls, especially where heterosexual sex is the main mode of transmission. In Sub-Saharan Africa, 57 percent of PLWHA are female, and in Russia, the proportion of women among newly infected people rose from 24 percent in 2001 to 38 percent in 2003.

Several factors increase women's vulnerability to infection and limit their access to HIV care and treatment. These include biological and cultural factors, social and economic gender inequalities, violence against women, women's unequal access to information, education and services, and their role as caregivers. In addition, in many societies women take on most of the care of people infected with HIV/AIDS. In Viet Nam, women make up 75 percent of all caregivers for PLWHA.

Among adolescents (aged 15-19) in regions hardest hit by the epidemic, for every boy five or six girls are infected. Young girls are physiologically more at risk of infection, are often poor and powerless, and are frequently coerced or enticed into sexual activity with older men in exchange for money, gifts and favors. For many young women marriage does not provide protection either, as young brides often lack the power to negotiate safe sex practices.

The feminization of the epidemic is an additional impetus for redressing the social, economic and legal inequalities women face and working to end violence against women. HIV/AIDS prevention and treatment programs must consider women and gender issues. Preventive methods that are controlled by women—such as microbicides and female condoms—can help reduce their vulnerability. As antiretroviral treatment is scaled up, more than ever there is a need to ensure equal access to services. Integrating HIV/AIDS with reproductive health programs may help improve women's access, especially where stigma and discrimination against people with HIV make women reluctant to seek HIV/AIDS services.

Source: UNAIDS 2004; UNAIDS/UNFPA/UNIFEM 2004, Women and HIV/AIDS: Confronting the Crisis.

- Lack of effective tools to measure environmental effects, obstacles and interventions, and the related tendency of programs to neglect whatever cannot be measured or reported as a "deliverable."
- Insufficient assessment of social factors in planning and implementing programs to trigger ongoing feedback from stakeholders.
- Lack of mechanisms to ensure that social and political environments support efforts to prevent and reduce HIV/AIDS.
- Lack of empirical evidence and widely differing views on the relative roles of legislation and education in reducing stigma and protecting human rights.
- Political unwillingness of governments and some donors to invest in potentially effective but controversial interventions, such as harm reduction for drug users in favor of more politically "acceptable" interventions that may have limited effect on the national epidemic.
- Frequent exclusion of security and correctional services from the national dialogue around HIV, despite the high vulnerability of prisoners and military personnel and the ease of reaching them. Law enforcement's cooperation can also be helpful for interventions targeting injecting drug users.
- Focusing exclusively on women and working only with women's groups when considering gender issues, instead of also reaching out to men, recognizing that most decision-makers are men.

Donor challenges

AIDS programs are funded by four broad sources: countries themselves; bilateral donors, especially the United States' President's Emergency Plan for AIDS Relief (PEPFAR) and the United Kingdom's Department for International Development (DFID); private foundations, with the Bill & Melinda Gates Foundation and the Global

Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) being by far the largest; and multilateral donors including the regional development banks and the World Bank. A number of agencies, in particular UNAIDS and its cosponsors, provide technical assistance. Responses to HIV/AIDS have suffered from the distorting effect on program planning and implementation of the numerous policies and priorities of such a wide variety of donors. Some of these distortions occur out in the field and are the responsibility of the countries themselves, but others can be laid at the door of external partners and the way they go about providing assistance (and are common to many development aid programs).

Uncertain, short-term and tied funding; duplication; and donor pressure and politics can create distortions and difficulties

Problems include:

- Uncertainty about future funding, which discourages countries from making the large up-front investments needed to strengthen systems and leads to too much investment in short-term measures.
- Funding that is tied to specific sources of technical assistance or to a particular product, which distorts allocations, raises prices and reduces efficiency.
- Diverting funds from other development programs, undermining the AIDS effort in the long run by further weakening crucial sectors such as health and education.
- Inadequate support to countries to integrate HIV/AIDS programs into their national budget planning and management processes, including in Medium-Term Expenditure Frameworks and Poverty Reduction Strategies (in countries that have them).
- Competition among donors and among recipient agencies, leading to expensive duplication—or even conflicts—in programming.
- Pressure from donors to attribute concrete, politically prominent results to their specific funding, which can fragment national monitoring and evaluation systems and discourage investment in less visible outcomes such as strengthening national systems or infrastructure.
- Excessive influence of donor country domestic politics in funding decisions can result in inappropriate prevention and care schemes in local settings.

Emerging challenges: new issues for a changing epidemic

Growing awareness of the devastating impact of HIV/AIDS has translated into greater political commitment to confront the epidemic and its consequences. This commitment has resulted in an outpouring of new resources and initiatives, including the World Bank's Multi-Country HIV/AIDS Program (MAP), the Global Fund, and major new commitments by government bilateral donors, such as DFID and PEPFAR. There are also significant funds from private institutions—notably the Bill & Melinda Gates Foundation. Altogether, total HIV/AIDS funds available in developing countries grew from an estimated US$300 million in 1996 to US$6.1 billion in 2004, including about US$ 2 billion in domestic funding, and to US$8 billion in 2005.[8] However, this is still $4-6 billion short of what is needed for effective prevention, care and treatment.

This increase in funding is a dramatic change and poses new challenges with which the AIDS community is still grappling.

Providing large-scale antiretroviral therapy

Evidence from developed and developing countries has shown that current treatment regimens can dramatically prolong the lives of persons living with HIV, enabling them to remain productive and raise their children. But only about one million of the six million people who currently need antiretroviral therapy in developing countries are receiving it.[9]

The delivery of ART in resource-limited settings, once thought impossible, has been shown to be feasible. For example, universal access to ART in Brazil has, since 1996, enabled the country to avert more than 60,000 new cases of AIDS and 90,000 HIV-related deaths.[10] To extend these benefits to other parts of the world, the Bank supports a comprehensive approach to care for people infected with HIV which includes antiretroviral treatment. The Bank provides technical and financial support to national ARV treatment programs in several countries, has developed a technical guide on procurement of AIDS medicines and supplies which has been en-

dorsed by UN agencies, and has entered into an agreement with the Clinton Foundation to ensure that Bank funds may be used to procure ARVs and diagnostics at the Foundation's negotiated reduced prices.

Achieving the goal set by the World Health Organization and UNAIDS of putting three million people on treatment by the end of 2005 ("3 by 5") will require much more than money, and poses new challenges.[11] To maximize individual benefit and to minimize the risk of patients developing resistance to ARVs, measures need to be taken to ensure that treatment is made widely available, can be sustained and that people adhere to their regimen. The need to strengthen health services is made even more urgent by the greater emphasis on treatment. Health systems are already overburdened and understaffed. Expanding treatment will require substantial new resources, especially investments in operational infrastructure, in training and retaining more health workers, and sustained additional funding. Staff need to be trained to prescribe ARVs appropriately and to monitor patients and treatment outcomes. Reliable, sustainable supplies of the drugs must be ensured; which may require additional investments in the supply chain and its management and improved procurement procedures. Additional laboratory capacity is needed to support HIV testing and management of ARV treatment. Much of this work will fall on the public sector, but private providers have an important role too, with appropriate stewardship from the public sector.

Another critical issue is to ensure equitable access to treatment programs. In some countries, gender inequalities already prevent many women from accessing care and treatment services. The design and implementation of treatment programs need to address gender and other dimensions of equity such as access for poor and marginalized groups and in rural areas.

The "Gleneagles" G8 summit in July 2005 recognized the need for additional efforts and funding to implement a package for HIV prevention, treatment and care, and to strive for universal access to treatment for all who need it.[12]

Staying the course on prevention

Preventing HIV infections should remain a priority for all countries, whatever the level of prevalence, while also treating and caring for people who are infected and affected. Since HIV is invisible in its early stages, countries with low HIV prevalence are often slow to respond and especially reluctant to use limited resources and budgets on prevention efforts. However, inaction is costly in all contexts. It inhibits response in low-prevalence countries at all levels: from policy formulation to prevention planning, implementation and ultimately to individual behaviour change. Intervening early, however, and working steadily and closely with key at-risk and vulnerable populations has proven effective in many countries.

Efforts to prevent new infections must be unrelenting. Even in the highest prevalence countries, the majority of people are uninfected, and need the information and means to remain uninfected. Effective prevention may require changes in social norms, attitudes and behaviours which are difficult to achieve. Populations at high risk of infection may be overlooked or underserved because of stigma, taboos and denial, or because governments shy away from controversial services or serving marginalised groups (such as clean needle programs for drug users or promoting condom use by sex workers and men who have sex with men). Even with respect to prevention in the general population, some institutions find it difficult to overcome the social barriers to dealing with sensitive issues surrounding AIDS. Sustained, strong political commitment, effective multi-sectoral efforts and broad community engagement are all needed for normative and behavioural changes that prevent HIV infection.

Efforts to prevent new infections must be unrelenting, alongside activities to expand treatment and care

Integrating prevention and treatment

It will be important to make sure that the promise of treatment programs does not slow momentum on prevention, especially as governments may find it easier to support treatment regimens than more controversial measures such as condom distribution and promoting clean needles.

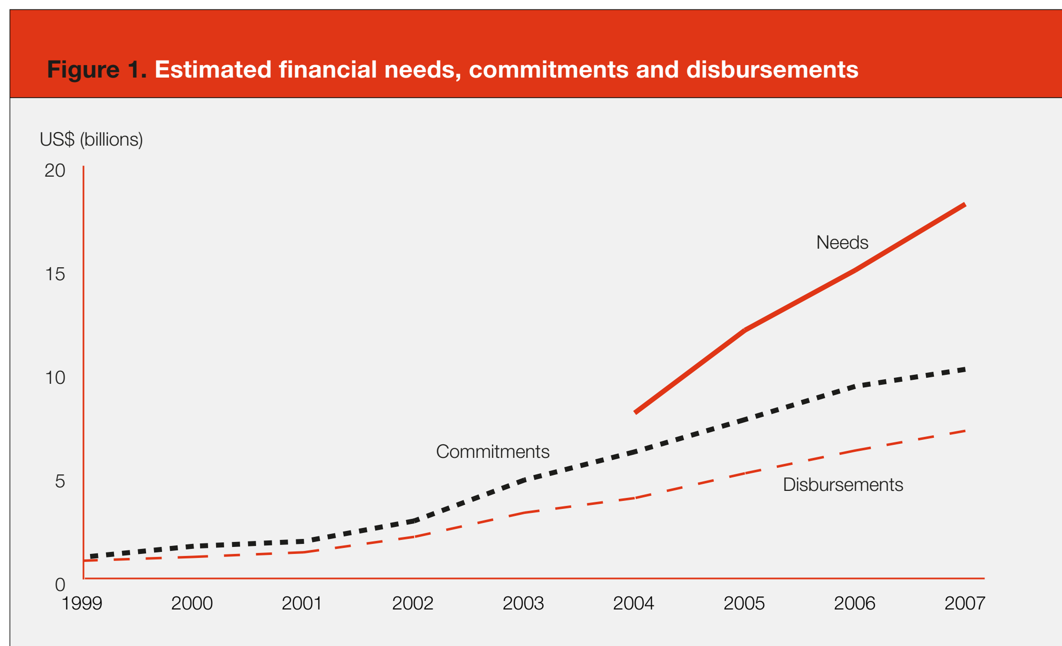
The impact of widespread treatment on prevention efforts is currently unknown: there can be important synergies, but there are also concerns about unintended consequences. For individuals, the possibility of treatment may provide the incentive and rationale for being tested, and testing provides an entry point for delivering prevention and treatment services. An HIV-negative test result could reinforce motivation to practice safe behaviors. Availability of treatment and care can bring large numbers of people into health care settings, providing additional opportunities for health-care workers to deliver and reinforce HIV prevention messages and interventions. In some developed countries, wide availability of treatment has coincided with an increase in risky behavior, perhaps because people are worrying less about becoming infected. The impact of expanded treatment programs on risky behaviours must be carefully monitored, and promotion of safe behaviours integrated into treatment programs. It would be a sad irony if increased access to treatment came at the expense of a general lowering of vigilance against infection and a greater number of new infections. Conversely, the more successfully countries prevent new infections, the more feasible, affordable and sustainable it will be for them to provide ARV and other treatment to people who are infected. In addition, prevention can enhance access to treatment, by reducing stigma and improving community knowledge and treatment readiness. Integrating prevention and treatment ensures that prevention activities are not neglected and can provide important opportunities to address vulnerable groups more effectively.

Funding commitments have surged ahead of their use, but are still far below needs

The funding paradox

The recent surge of funding has created a paradox: there is still not enough money available for HIV/AIDS programs, but the money that is available is not being spent as fast as it is being committed. Figure 1 shows the June 2005 UNAIDS estimate of annual needs for HIV/AIDS programs along with the best current estimate of available commitments and actual and projected disbursements.[13] Funding commitments are still substantially below estimated needs, leaving a "resource gap". Disbursements are increasing, but they are not keeping pace with commitments, resulting in an "implementation gap." There are not always adequate systems in place—in recipient countries as well as in donor institutions—to put increased funding to use in a timely and effective manner, creating disbursement bottlenecks. Funding increases have raised expectations among donors and people living with HIV/AIDS, but overwhelmed many of the in-country mechanisms through which those expectations must be met.

Figure 1. Estimated financial needs, commitments and disbursements



This implementation gap threatens to dash rising expectations (to be treated with ART, for example), and risks alienating donors who assume that more money means more and faster results. In the rush to bridge the gap and produce results, there is a real risk that planning will become even more neglected, that funds will be spent inefficiently, and that accountability will be minimal. This intensifies the need for donors and others working on HIV/AIDS to harmonize their efforts and align their activities, to make the most efficient use of resources and to support country-owned and implemented strategies. Many hard-pressed governments find themselves spending more time managing competing donor demands than establishing their own priorities and implementing their own programs.

The Three Ones and the Global Task Team process is critical both in raising increased resources and in ensuring that these resources are allocated well and used effectively to improve implementation and use of existing funds (See Box on The Three Ones).

To close the resources gap, more progress is needed towards closing the implementation gap. This requires that donors and recipients do more to promote faster disbursements while at the same time maintaining high levels of efficiency, effectiveness, transparency and accountability. Neither recipients nor donors can continue to do "business as usual". Dr. Peter Piot, Executive Director of UNAIDS, has called AIDS "an exceptional epidemic . . . that demands exceptional actions."[14] The Bank has begun to use nonstandard implementation arrangements in the Multi-country AIDS Program (MAP)[15], and to change its procedures to speed up implementation. This flexibility has not always been matched by governments, many of whom continue to address HIV through existing and often rigid bureaucratic procedures.

HIV is often overlooked in the poverty reduction strategy process and medium term expenditure frameworks

In many countries, AIDS has a disturbingly low profile, for a number of reasons: stigma or denial may prevent political commitment or a vocal civil society from materializing; concentrated epidemics may be invisible to the general public; and AIDS authorities may carry little weight in government circles. This is evident in some Poverty Reduction Strategy Papers (PRSPs). A recent study of HIV/AIDS in PRSPs in Africa showed that while it was addressed by many—but not all—countries with a high prevalence, it was less likely to appear in PRSPs in countries with emerging epidemics.[16] Moreover, even if HIV was prominent in PRSPs, it was rarely costed, and the institutional framework for implementation was detailed in only 10 percent of cases.

As a consequence, funding for HIV/AIDS can easily be ignored when donors pledge support for PRSP implementation. Country-level stakeholders and international partners need to keep HIV on the agenda during the PRSP process and during other national budgetary processes such as developing Medium-Term Expenditure Frameworks (MTEF). National HIV/AIDS strategies need to be embedded in national public expenditure planning and taken into account during macroeconomic policy debate. With renewed global focus on Africa, there is a pressing need to ensure that HIV/AIDS is addressed in the wider development agenda and development instruments.

AIDS needs to be better integrated into broad national development planning and budgeting

PRSP and MTEF processes and macroeconomic policy dialogue also offer opportunities for considering broader policies and actions that are linked to a country's ability to respond to HIV/AIDS (for example, investments in the health sector including expanding the health workforce and retaining health workers) and to gender factors such as girls' access to education and women's property rights, that can affect poverty and vulnerability and women's ability to protect themselves from infection.

Predicting the social impact of a still growing and diverse epidemic

While the demographic impact of the HIV epidemic is becoming increasingly apparent in much of Africa, we can only speculate about its full economic and social impact. At the household level, the main effect of AIDS is to increase poverty, especially among the poorest. Because AIDS affects mainly adults in the prime of their lives, it results both in a

Making the money work—"The Three Ones" in action

In April 2004, the UNAIDS co-sponsors, the Global Fund, the World Bank and key bilaterals including the U.K. and the U.S. agreed to support the "Three Ones" at country level in order to improve the efficiency and effectiveness of HIV/AIDS funding.[1]
The "Three Ones" are:

- One agreed HIV/AIDS action framework to coordinate the work of all partners;
- One national AIDS coordinating authority with a broad-based multi-sectoral mandate; and
- One agreed country-level monitoring and evaluation system.

Eleven months later donors and recipient countries met in London to assess the "Three Ones". While there was progress in some countries, not enough countries and donors were putting the "Three Ones" into practice. UNAIDS was asked to facilitate formation of a Global Task Team to issue within 80 days recommendations on improving AIDS coordination among multilateral institutions and international donors. Task forces were established on strategy and funding, technical assistance, and monitoring and evaluation. The Bank co-chaired the task force on strategy and funding and was a member of the group on monitoring and evaluation as well as the overall Global Task Team.

The Global Task Team (GTT) presented its recommendations within the 80 day deadline.It also reached agreements on improved coordination between the Global Fund and theWorld Bank, and the division of labor among the UNAIDS co-sponsors, particularly with regard to rationalizing the provision of technical support. The division of labor suggested that the World Bank take the lead in assisting countries to enhance their HIV/AIDS strategies by making them more prioritized, evidence based and inclusive and by establishing annual actions plans for better implementation. Together with UNDP, the Bank will help countries better integrate their HIV/AIDS programs into the broader development agenda, including in PRSPs and Medium Term Expenditure Frameworks.

The World Bank is also participating in costing the implementation of the GTT recommendations with regard to technical support and in the creation of two new mechanisms for promoting coordination: (i) joint country support teams for monitoring and evaluation; and (ii) a UN system-Global Fund problem-solving team to operate at both country and global levels.

1. The "Three Ones" agreement was endorsed by representatives of the governments of Australia, Belgium, Brazil, Canada, Côte d'Ivoire, Denmark, Finland, France, India, Ireland, Italy, Japan, Luxembourg, Malawi, Netherlands, Norway, South Africa, Sweden, UK and USA, and of the following organizations: UNAIDS, UNDP, WHO, World Bank, OECD, OECD/DAC, International Council of AIDS Service Organizations (ICASO), and the Global Network of People Living with HIV/AIDS (GNP+). For more details on the Three Ones, see UNAIDS 2004, *Coordination of National Responses to HIV/AIDS, Guiding principles for national authorities and their partners*.

rapid increase in the number of people needing treatment and in the number of orphans, who are often deprived of access to education. Even if governments are able to provide long-term ARV treatment to rapidly growing numbers of people, many infected adults will still die before their children reach maturity.

Given current trends, vulnerabilities and patterns of behavior, it seems unlikely that the large nations of Asia will suffer HIV epidemics in the general population such as those now seen in Southern Africa. However, behavioral patterns do change, and AIDS specialists have been wrong before in predicting the course of the epidemic. Even if current"worst case"scenarios for large countries do not come to pass, at the very least, Eastern Europe and parts of Asia are likely to see large, concentrated epidemics affecting millions of people—and creating vast new demands for prevention, care, support, and treatment.

Notes

1. UNAIDS. *2004.*
2. UNAIDS. *2004*

3. World Health Organization Department of Child and Adolescent Health and Development. The Talloires consultation to review the evidence for policies and programmes to achieve the global goals on young people and HIV/AIDS. Information Brief 11.10.04, http://www.who.int/child-adolescent-health/New_Publications/ADH/IB_SRG.pdf

4. "Health systems" include a range of functions whose *primary* purpose is promoting, restoring and maintaining health. The areas of concern most relevant to this Program of Action are stewardship (oversight and the roles of the state); financing (revenue generation, collection, pooling, allocation, use and sustainability); epidemiological surveillance as an input into evidence-informed planning, implementation and evaluation of programs; service delivery, including supply chains and the multiple dimensions of quality care; human resources (quality, quantity and performance incentives); and infrastructure for effective prevention and treatment, including laboratory facilities and communications.

5. Wagstaff A, and M. Claeson, 2004. The Millennium Development Goals for Health—Rising to the Challenges, World Bank, Washington DC.

6. UNAIDS 2005. *Information Update.* General Assembly High Level Meeting on HIV/AIDS. New York, 2 June 2005.

7. Wagstaff A, and M. Claeson, 2004.

8. UNAIDS. *2005.* "Resource Needs for an Expanded Response to AIDS in Low and Middle Income Countries", Discussion Paper: 'Making the Money Work', The Three Ones in Action, United Kingdom, 9 March 2005.

9. WHO and UNAIDS, 2005, "The 3 by 5 Initiative", report on progress as of June 2005, accessed online on August 8, 2005 at: http://www.who.int/3by5/progressreportJune2005/en/

10. Teixera, Paulo R., Marco A. Vitoria, and Jhoney Barcarolo. 2004. "Antiretroviral treatment in resource-poor settings: the Brazilian experience." *AIDS* 18(3): S5-S8.

11. WHO (World Health Organization). 2003. *Treating 3 Million by 2005: Making It Happen: The WHO Strategy.* Geneva: WHO Department of HIV/AIDS. [www.who.int/3by5/].

12. Gleneagles Communiqué, Page 22, paragraph 18 (d).

13. UNAIDS 2005. Resource needs for an expanded response to AIDS in low and middle-income countries. Presented at the Programme Coordinating Board; seventeenth meeting. Geneva, 27-29 June 2005.

14. Piot, Peter. *AIDS: The Need for an Exceptional Response to an Unprecedented Crisis.* Presidential Fellows Lecture delivered on November 20, 2003 at the World Bank, Washington, D.C.

15. As described in the MAP operations manual published as "Turning Bureaucrats into Warriors", Brown, Ayvalikli and Mohammad, World Bank, 2004.

16. World Bank and UNICEF, 2004. Poverty reduction strategy papers—Do they matter for children and young people made vulnerable by HIV/AIDS? UNICEF, New York. On line at http://www.unicef.org/publications/index_24887.html