HLSP Institute

Five ways to begin the end of AIDS

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Beginning 'the end of AIDS' requires re-thinking critical elements of global, regional and country AIDS programming.

This paper proposes five ways forward that challenge decades of institutional thinking.

Is recent optimism about the 'end of AIDS' justified? Peter Godwin and Clare Dickinson argue that for the end of AIDS to become a reality, radical re-thinking is needed. They suggest five critical areas that AIDS policy-makers, programmers, implementers and thinkers will need to consider.

Good news, but ...

2012 brought a flurry of good news for AIDS: the 'end of AIDS' purported to be in sight, the UNAIDS Investment Framework as the 'answer' to more efficient and effective responses, PEPFAR's Blueprint to fund it, the resuscitation of the Global Fund to pay the rest, and the UNDP Global Commission on HIV and the Law to keep responses grounded in human rights. Reactions to this good news suggest that for many this means more focused effort, and still greater funding and advocacy, to make sure the discourse doesn't get distracted by changing priorities in the health and development sectors.

We would like to suggest, however, that an end to AIDS requires radical re-thinking – especially if the huge political, financial and programme investments of the last decades are not to be wasted. We suggest five areas that AIDS policy-makers, programmers, implementers and thinkers need to consider.

Five ways forward

1. Far more precise focus on country-level targets

The 2011 High Level Meeting (HLM) targets for HIV provided a new, target-based, time-bound roadmap for achieving the UNAIDS' vision of 'getting to zero' and ending AIDS. These targets are important for four reasons:

- They describe (mostly) the actual outcomes required for the end of AIDS – such as reduced incidence, increased numbers on treatment – rather than the processes to get there, e.g. the number of people reached with services or number of people tested.
- They are specific, time-bound, measureable and realistic.
- They are sufficiently precise that programmes can be held accountable for reaching them – or not.
- They are globally accepted.

However these targets are proving difficult for countries to 'domesticate', and seem to have slipped into the background. The UN Secretary General reported to the UN

Achieving the HLM targets at country level means doing things differently from the past, and targeting investments where they will have maximum impact.

General Assembly that the targets were unlikely to be met; UNAIDS confirms this.[1] Research undertaken by HLSP in Asia in 2012 looked in some detail at why very few countries in the region are likely to reach the targets.

A large part of the problem is that countries are still focused on funding what they want to do, rather than doing what they need to do with the funds they have.[2] There is potentially much less political appetite for the kinds of prioritisation of spending and investment that, for example, the UNAIDS Investment Framework calls for. It is important that the Global Fund finds its appropriate place in addressing these issues.

A significant shift in thinking must be to move away from 'prevalence' towards greater focus on incidence if prevention targets, and investment to achieve them, are to be made meaningful at country level. This is not without challenges; but the models, and some methods, for incidence assessment have been developed, tried and tested. They now need to be applied on a large scale. Robust commitment to coordination is required. We found no less than three incidence modelling/ measurement programmes in Asia, very poorly coordinated with one another – a situation causing confusion in countries, distrust among professionals, and signalling lack of progress in key areas. Our research from the region indicates that countries are still far from the point of significantly reducing incidence rates, and many are struggling to develop national strategies that include even basic data and targets for incidence and treatment.

2. Sharpen and prioritise the objectives of AIDS programming and explicitly plan to achieve them

The luxury of trying to do everything in the hope that some of it will have an effect no longer exists.

Greater clarity on the primary objectives of AIDS programmes in today's world is required: direct outcomes related to incidence, morbidity and mortality[3], or broader outcomes related to civil society engagement in politics, human rights advances, democracy and enlightenment.[4] While the thirty years' experience of the AIDS epidemic has shown that these two sets of aims are closely intertwined, the UNAIDS investment approach requires that clear choices be made between them in specific country and programme contexts. The luxury of trying to do everything in the hope that some of it will have an effect no longer exists. Urgent focus on the immediate drivers of the epidemic in specific country situations is needed; as is immediate access to services for the most affected populations.[5,6] The larger issues need to be addressed through other broader health, social welfare and governance programmes in which AIDS programming must be contextualised.

Strategic investment may improve the effectiveness of responses. But this will require a re-orientation of the 'policy consensus' and political negotiation with major partners and agencies.

Mead Over's 'AIDS transition' provides a compelling case for eliminating the global burden of the AIDS epidemic and for significantly re-orienting global and country AIDS policy and programming objectives. Over argues that the end of AIDS will only begin when countries aim for a point when the number of new HIV infections falls below the number of deaths, so that the total number of people living with AIDS in any one country, and the associated cost and dependency, begins to stop growing.[7] This new paradigm reveals very clearly not only how much further, beyond the simple HLM targets we have to go, but also the financial implications of progress, and more probably, lack of progress. It is disappointing there isn't more appetite among the international AIDS community to explore this critical approach further.

3. Support countries by developing consensus on global, regional and country results frameworks that address sustainable AIDS responses beyond 2015

While country ownership is a cornerstone of good development, countries are highly influenced by global and regional consensus when it comes to many socially challenging issues like HIV and sexual and reproductive health. Current AIDS frameworks tend to be dominated by the Geneva-Washington axis, and focused on

Countries need support in moving towards effective *local* results frameworks.

a one-size-fits-all global response that reduces everything to the lowest common denominator in order to be inclusive. But we now recognise that HIV epidemics are significantly different in Sub-Saharan Africa, Asia, Latin America and Europe, requiring diverse and more appropriate regional results frameworks that in turn can be used to support countries as they try to determine more effective local results frameworks.

4. Resolutely re-assess the architecture for AIDS programming in countries

Much of the AIDS architecture is no longer fit for purpose.

Much of it is not (or no longer) fit for purpose. In spite of the enormous political, institutional and financial investments in National AIDS Commissions (NACs) and the 'expanded multi-sectoral response', it is critical that leaner, meaner programme responsibilities and accountabilities are salvaged and supported, and embedded within universal access to health care. The importance and contribution of NACs has been widely reviewed and often found wanting.[8] Our research found that in the largely concentrated epidemics of Cambodia, Indonesia, Laos and the Philippines, management and administration associated with a multi-sectoral approach, better suited to generalised epidemics, accounted for more than 20% of total programme costs in 2009. Some 22% of all Global Fund grants to the region and 21% of all UN funding was used for management and administration in 2009.

The concern for the coordination process and architecture that the NACs represent can distract from focusing on scaling up effective programming. Health ministries and health systems have grown dramatically in scope and scale since the days when AIDS presented a major coordination challenge. Effective public health programming for key affected populations as part of Ministry of Health core business is now in place in many countries, and needs to be strengthened.

5. Re-locate HIV and AIDS programming within emerging health systems approaches to improve health and social welfare outcomes for both general and specific population groups

AIDS is no longer 'the greatest development challenge'

While vigorous advocacy for AIDS programming played a key role in creating global awareness of the specific challenges associated with HIV and AIDS, AIDS is no longer the 'greatest development challenge the world faces'. The time has come to find the appropriate place for AIDS within the enormous health and social welfare challenges that post-MDG policy and programming will face at country level.[9] As attention increasingly shifts onto the new, post-MDG overarching frameworks of universal access for health and health systems, the growing threat of non-communicable diseases, and the re-alignment of external funding, the AIDS stewards (at both country and global level) need to find appropriate ways to incorporate not only their present requirements, but also the lessons they have learned, into these frameworks.

Look forward, not back

These five ideas challenge decades of established and embedded institutional thinking – about AIDS in relation to health, society, development – and decades of sincere personal commitment by individuals. But if 'the end of AIDS' is to be achieved, these challenges must be faced.

Although it will take time for organisations and institutions to transform, there is scope for determined individuals to influence change. As 2013 starts, be one of those who looks forward; not one of those who looks back.

This Comment was written by Peter Godwin (Independent Consultant) and Clare Dickinson (HIV Specialist with HLSP).

References

[1] UNAIDS (2012) Together We Will End AIDS.

[2] See African Union (2012) Roadmap on Shared Responsibility and Global Solidarity for AIDS, TB and Malaria Response in Africa.

[3] The 2011 High Level Meeting targets.

[4] See for example: UNAIDS Perspectives on the Critical Elements and Impact of a Rights-based Approach to HIV and Beyond (2013). Thematic paper for the online consultation on 'Health in the Post-2015 Development Agenda'.

[5] Foley E and Hendrixson A (2011) From Population Control to AIDS: Conceptualising and Critiquing the Global Crisis Model.

[6] Oberth, G, Tucker P and T Alakija (July 2012) Strengthening Africa's Country Coordinating Mechanisms through Empowerment of Marginalized Communities: who is really affecting the Global Fund decision making processes? AIDS Accountability International.

[7] Mead Over (2011) Achieving an AIDS Transition: Preventing Infections to Sustain Treatment.

[8] See for example: the references in Godwin P et al. (2006) Five Myths about the HIV Epidemic in Asia. *PLoS Med,* vol. 3, no. 10; Dickinson, C et al. (2008) A Synthesis of Institutional Arrangements of National AIDS Commissions; England R (2006) Coordinating HIV Control Efforts: What to do with the national AIDS commissions. *Lancet* 367: 1786–1789.

[9] See for example World Economic Forum (2013) Sustainable Health Systems Visions, Strategies, Critical Uncertainties and Scenarios. A report from the World Economic Forum, prepared in collaboration with McKinsey & Company.