



**Presenters:** from Brazil, the Director of the National STD/AIDS Program, Dr. Alexandro Grangeiro; from Senegal, the Executive Secretary of the Conseil National de la Lutte contre le SIDA, Dr. Ibra Ndoeye and the Deputy Executive Secretary Madam Katy Cisse Wone; from Thailand, the Director of International Health Policy Program of the Ministry of Public Health, Dr. Tangcharoensathien Viroj and the Chief of the AIDS Cluster from the Ministry of Public Health, Dr. Somyot Kittimungkong; from Uganda, the Director-General of the National AIDS Commission, Dr. David Kihumuro Apuuli, and the Program Manager of the STD/AIDS Control Program in the Ministry of Health in Uganda, Dr. Elizabeth Madraa.

**Moderators:** Ms. Meskerem Grunitzky-Bekele, UNAIDS, Dr. Michel Kazatchkine, Director, Agence Nationale de Recherches sur le Sida (ANRS), France. Dr. Gottfried Hirnschall, Director, Partnerships, External Relations and Communication, HIV/AIDS Department, WHO and Mr. Brad Herbert, Director for Strategic Development at the Global Fund for HIV/AIDS.

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**JOINT WORLD BANK / UNAIDS SEMINAR ON**

**“RESPONDING TO THE HIV/AIDS CRISIS:  
LESSONS FROM GLOBAL BEST PRACTICES”**

*Sharing Ideas from  
Brazil, Senegal, Thailand & Uganda*

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## *Summary and Comments*

### *Introduction*

The AIDS epidemic has emerged as a devastating global crisis that continues to worsen and has become a major obstacle to economic and social development. So important is this issue that an eminent group of economists recently concluded that dealing with it is the number one priority among the ten most important global issues, not only for humanitarian reasons, but even from a purely cost/benefit point of view. As part of continuing efforts by the United Nations to better assist countries as they intensify their national AIDS responses and allocate financial resources accordingly, the World Bank and UNAIDS organized a seminar in Geneva in June, 2004 to examine lessons learned from global best practices in four countries implementing effective campaigns against HIV/AIDS. The purpose of the seminar was to compare lessons from the field and share that knowledge with people from countries that are dealing with the difficult choices that need to be made when tackling the epidemic.

The seminar engaged in a cross-country analysis of national responses, conceptualized and implemented in entirely different social, cultural, political and economic settings, to identify common policies and practices in dealing with the HIV epidemic. Representatives from the participating countries – Brazil, Senegal, Uganda and Thailand – spoke openly of their successes and failures and made recommendations that could prove useful to other practitioners facing similar situations. In light of their varied country profiles, the lessons learned may not necessarily be applicable to all countries, but could serve as a basis for identifying effective, evidence-based strategies. This paper presents the common elements for success and the specific lessons learned from the very active programs in the four countries. It aims to support the sharing of information, the cross-fertilization of ideas and possible application in other countries.

### *Common Elements for Success*

The following summary highlights the key common elements for success identified by the country representatives who spoke about their programs at the seminar. They are all specialists in their fields, with years of experience in the battle against HIV/AIDS.

#### *Early Action and High-Level Leadership*

All speakers acknowledged that as they confronted the AIDS crisis early on, it was very important to take action as soon as possible and begin by breaking the silence on AIDS at the highest level. In Uganda, for example, the President spoke out personally on the urgency of the need for action and participated in events related to the campaign. In Thailand the Prime Minister chaired meetings of the National AIDS Prevention and Control Committee and the program became part of the country's five year plan. In fact, the political leaders in all four countries, by speaking openly about AIDS, enabling an early response, and embracing the efforts being undertaken, have been instrumental in strengthening the national programs, sustaining them when difficulties arose, and ultimately in stabilizing or reducing the prevalence of HIV.

## *Coordination of the National Response*

It is clear from the presentations that a critical element for success in all four countries has been the creation of a national AIDS coordinating body with the power to oversee many sectors to ensure broad-based continuity. This body has the mandate to coordinate the work of all partners based on a national AIDS framework that serves as the basis for all interventions: international, national, or local. The national authority coordinates the contributions of outside donors, orchestrates activities of different sectors, acts as a centralized funding mechanism and oversees the national response, including the contribution of civil society. The countries' experiences showed that the coordination authority was instrumental in implementing a multisectoral response. The national response also includes the need to monitor and evaluate the country program so as to identify weaknesses and help modify efforts that are not achieving desired results. During the discussions it was noted that in an effort to improve the impact on the ground, a major international conference on AIDS in 2003 recognized the importance for governments to implement the principles of the Three Ones: a single action framework, a single national coordinating body and a single monitoring evaluation system. The location of the national AIDS coordinating authority, however, may differ according to the institutional arrangements in the country. For example, Senegal, Thailand and Uganda have established supra-ministerial national AIDS committees, but in Brazil the Ministry of Health serves as the coordination authority. It was also observed that Thailand, Brazil and Senegal, which were able and committed to allocate funds from the national budget to build an AIDS response, have developed more sustainable responses that better address national priorities.

## *Multisectoral Approach, Community Participation, Communications and Decentralization*

Once they launched their national HIV/AIDS programs, all four countries rapidly adopted multisectoral approaches to expand their impact. Brazil involved schools, universities, social institutions, faith-based groups, the judiciary, unions and the private sector. They mobilized the general public through information campaigns, some national, some to targeted audiences. Two groups have been particularly important in Brazil, the UNAIDS theme group and the Business Council, which unites activities of unions and corporations. Thailand spoke of the need to develop a common vision through massive information campaigns on television and radio to address the problem of the stigma attached to the disease. In Uganda, the national commission includes stakeholders from a cross-section of civil society: NGOs, faith-based groups, youth, the media, research groups and people suffering from AIDS. In Senegal, informational publications on prevention were endorsed by both Muslims and Catholics and televised debates helped spread information. In other words, the national efforts, although sometimes housed within and definitely involving the Ministry of Health, also mobilized different sectors to take action and funneled resources to ensure that other actors could implement their programs. The existence of strong civil society/communities and NGO groups in the four countries has been catalytic in putting pressure on the public sector and extending the network of prevention and care activities.

In government, the programs involve effective implementation at the national, state and local levels. The decentralization of the national AIDS response was accompanied not only by financial decentralization, but also the fostering of local responses. Local governments and (grassroot) civil society organizations were encouraged to jointly plan and implement AIDS programs monitored by federal governments. Building on existing structures, networks and mechanisms was also vital to accelerate implementation. Brazil and Thailand have achieved decentralization and scaling up of the AIDS response by using existing strong decentralized health systems. In Brazil, half of the available resources are transferred on annually to states

and districts to support annual action plans. Thailand successfully promoted condom use by utilizing the existing decentralized family planning network as its operational network.

### ***Achieving a Balance between Prevention and Treatment***

All four countries are maintaining programs that continue to sustain effective prevention measures while introducing strong antiretroviral treatment programs. Maintaining the balance between prevention and care improves the quality of life of people living with HIV, while reducing the number of new infections. This approach has been instrumental to their success. Effective monitoring and evaluation programs help ensure the impact of the programs being implemented. In Brazil there are now five regional evaluation centers that harmonize research results, health training and specific evaluation indicators under the national program. It maintains a system of laboratories for viral and CD4 testing.

Maintaining prevention efforts at the highest level and promoting behavior change continues not only in the most vulnerable groups but also in the general population. Condom use has been promoted in all programs. The prevention of mother-to-child transfer has been emphasized. Care has been taken to ensure a safe blood supply. The programs have targeted vulnerable groups with their prevention programs: the poor, youth and women, sex workers, homosexuals, drug users, prisoners, and orphans. Taking advantage of access to large groups through institutions like schools, unions, religious groups and the media, for example, to pass information has proved effective. In Thailand local production of condoms has been subsidized and enabled massive distribution at very low cost. In Senegal the challenge now is to create a response at the rural community level, including the most remote regions which have not yet been active in the fight and where 65 percent of the population is living.

Even in a specific context where religion has a great influence on behavior and decision-making, it is possible to adapt strategies by involving religious leaders early and working with them. In Senegal, for example, information leaflets on the use of condoms include verses from the Koran and quotations from the Bible. In Brazil the Catholic Church has been important to acceptance of the prevention programs at the grassroots level, although achieving that support was not easy. In Uganda faith-based groups have been extremely active at the local level.

Since the availability of effective antiretroviral treatment programs changed the outlook for the afflicted, a much more positive dynamic has entered the picture, enabling programs to expand, but also necessitating the consideration of the costs of providing antiretrovirals to the public. In Brazil, in 1996, the choice was made to provide antiretroviral treatment to all sufferers, free of charge. Thailand is promoting access to antiretroviral treatment and care in a step-by-step approach, progressively prioritizing the allocation of resources according to capacity and availability of funds. However, Uganda, which has relied more on external support, promotes the rapid scale up of treatment and care, whilst seeking other resources to ensure sustainability. In Senegal antiretrovirals have been made available for free since January 2004.

To make universal access a reality and ensure its sustainability, the country representatives indicated that several strategies should be considered at the same time: price reductions, production of generic drugs, mobilization of additional resources and increased national budget allocation to avoid over dependency on external resources and cope with resource flow interruptions. In its efforts to keep costs low, Brazil vigorously advocates more favorable terms for pharmaceutical products for developing countries, maintains a system of national laboratories for research, produces generic drugs locally, and finally negotiates internationally for reduced drug prices on imported products.

## ***Addressing the Challenges***

### ***Expanding Counseling, Testing, Treatment and Human Resource Capacity***

All four countries recognized there are challenges associated with using increased resources to scale up their programs, especially in the area of antiretroviral treatment. For example, expanding voluntary counseling, testing and the provision of antiretroviral treatment to all those who suffer from the disease creates an urgent need for large numbers of trained staff and a surge in demand for drugs. This adds stress to already strained training facilities, distribution networks, and procurement practices. A shortage of human capacity is now a big challenge in Uganda and Senegal. The shortage is caused not only by the increased demand, but also the impact of AIDS on professional staff, and the migration of trained, public-sector professionals to more lucrative employment.

Both Brazil and Thailand, which have a long record of successful implementation of prevention efforts, also noted the difficulties associated with expanding voluntary counseling and testing services as well as free antiretroviral therapy. In Thailand, after about a year's experience implementing such a program, they reported that thousands have enrolled in the Ministry of Public Health program as well as other government and private sector schemes. The government is working closely with the World Bank and other groups to manage the costs and consequences of the increased therapy. The experiences of Thailand show that a pragmatic approach to planning and implementation of the response, based on availability of technical and financial resources, is instrumental in addressing the human resource challenge. It has introduced incentives to retain trained professionals within the public sector and insists that young trained professionals work three years in rural areas after graduation. Thailand feels that sustainability needs to be ensured by the national authority, recognizing that external support should not drive the response.

### ***Working in Partnership***

In their discussion, participants concluded that despite the gravity of the global AIDS crisis, the world is responding more effectively with increased financial support for national responses, which need in turn to be well focused, well organized, dynamic and flexible. At the same time, they commented that the heavy bureaucracy of global funding initiatives and international organizations can delay national efforts to implement stronger responses. Some countries are burdened by excessive demands of numerous external actors who may cause confusion to ongoing efforts. They said international and national partners must increasingly treat the AIDS epidemic as an emergency by developing more flexible and innovative funding mechanisms and programmatic approaches that keep in mind their limited human resource capacities. Clearly further efforts are needed to improve coordination and cooperation among international and national partners, given the exceptionality and global impact of the disease.

They also noted that technical assistance and experience shared among low- and middle-income countries is an important yet under-utilized tool. The four countries are already sharing their lessons, but this process can be better supported by external partners. In monitoring and evaluation, Brazil and Thailand have made important achievements through developing their national capacities to use modern technology to ensure a more sustainable public health response. They have promoted the transfer of their technology because it remains a challenge for many developing countries to develop their own technology to fight AIDS, e.g. national production of antiretroviral drugs, HIV tests, CD4 and viral load.

## *Transcript of the Proceedings*

### *Opening Remarks-- Introductions*

*Joseph K. Ingram, World Bank Representative, Geneva*

First I would like to welcome and thank you all for coming to this event sponsored by the World Bank Office in Geneva in collaboration with UNAIDS. We have chosen to bring together representatives of four countries that are in the forefront of the fight against HIV/AIDS, a pandemic that poses an unprecedented threat not only to the populations of these four countries, but also to global health, development and security. Dr. Peter Piot, Executive Director of UNAIDS, will speak more about that in his opening remarks.

The subject matter of today's seminar merits something more than our usual half-day discussion, both in terms of its length and in terms of the depth with which it is examined. Forty-two million people are known to be currently living with HIV/AIDS. I said currently known because this number is probably higher. More than 60 million are known to have been infected with HIV since it was first diagnosed more than 20 years ago. It is estimated there are 15,000 new infections every day. Many of them in your countries, as well as mine.

Recent studies highlight potential problems in some of the most populous countries, including India, China, Russia and Indonesia. Not only is the fight against this modern-day scourge a moral and public necessity, but it is also becoming a major obstacle to economic and social development. As one recent World Bank report states, if nothing is done quickly to stem the epidemic, "in those countries facing an HIV/AIDS epidemic on the same scale as South Africa...they could face economic collapse within several generations, with family incomes being cut in half."

Indeed, so critical is the problem for development that an eminent group of economists, including three Nobel Prize winners who met in May of this year as part of the "Copenhagen Consensus," concluded that among the ten most important global issues to be resolved, the first priority, from a purely cost/benefit point of view, would be a successful campaign to deal with HIV/AIDS. Their succeeding priorities among the ten they identified were: fighting malnutrition; reducing trade barriers and eliminating agricultural subsidies; and finally, improving measures to control malaria. As a recent article in "*The Economist*" magazine stated about these four priorities, "by the ordinary standards of project appraisal, they are...extraordinarily good, with benefits exceeding costs by a factor of ten or more and sometimes much more." Now we need to convince our politicians and our policymakers that they need to allocate financial resources accordingly.

This seminar is intended to contribute to that objective. As many of you here represent governments and will hopefully communicate back to your capitals, there are indeed cost-effective ways of dealing with the problem both in terms of prevention and treatment. Certainly we at the World Bank consider the benefits as enormous, and as a result we have in the last five years committed on the order of 1.5 billion dollars in grants, loans and credits to programs to fight HIV/AIDS, of which approximately 1 billion dollars have gone to Sub-Saharan Africa.

However, we cannot be effective as a donor working alone. As a result, we work very closely with partners to provide strategic analysis and policy advice and other technical expertise at the country level. As founding co-sponsor of UNAIDS, we work closely with them as well as with other UN agencies to deepen HIV/AIDS work at all levels. And today with UNAIDS, WHO, and the Global Fund for AIDS, we are here to **listen and learn** from four very different countries and different programs, programs from different parts of the globe with distinct cultural characteristics, varied incomes and socioeconomic levels, and different stages of program development. It is this cross-country analysis which will make this event unique and which should help us to take stock of successes both medical and non-medical. Hopefully it will allow us to identify common policies and actions which have led to progress in the fight against HIV/AIDS.

Our panelists today are here to be heard, and the lessons they bring will be important for all of us as well as for the institutions we represent. I would now like to turn the floor over to Peter Piot, who is the Executive Director of UNAIDS, who many of you know and who, with the World Bank, is co-sponsor of this event. Then we will ask Ms. Meskerem Grunitzky-Bekele, Associate Director of UNAIDS, to take the floor and to introduce the speakers for this morning's session.

*Peter Piot, Executive Director, UNAIDS*

I am also delighted to welcome you to this seminar that we are co-organizing with the World Bank and I speak to you as a ten percent World Bank staff member since the Bank is one of our nine co-sponsoring agencies. When Joe and I met for the first time about six months ago, we both felt that it was time to inform the development community here in Geneva of the work that the Bank is doing on AIDS globally. It is well known in the countries themselves, but here in Geneva it is not. I also felt that there are a number of original aspects of the Bank's work that are important to highlight, bearing in mind that the Bank is still the largest multilateral donor in Africa when it comes to AIDS.

I think that we are entering a completely new phase in the response to the AIDS epidemic globally and in many countries. The last 12 to 24 months have seen really an extraordinary momentum in the global response. A political momentum, a financial momentum and a momentum of hope. So a combination of these three – **leadership, money and evidence of hope** – really makes me think that for the first time in the history of the epidemic we have a true chance to be successful to contain it to make sure that the new generation will be HIV-free and that people living with HIV will have longer lives and better lives and that those who are left behind will be taken care of and be supported. But these new sets of opportunities also bring with them new challenges and exacerbate some of the existing old challenges. Let me very briefly go over them because I think they will probably come back throughout the countries' presentations today.

First, I want to start with the **funding**. There has been an enormous increase in resource commitments and in spending. When we started, we spent about 200 million dollars on AIDS in low-and middle-income countries. That was seven years ago. Last year we estimate it was 4.7 billion dollars. An enormous increase and most of that increase is money spent, not pledged. This enormous increase has been mobilized particularly over the last two years and will continue with the approval by the US Congress in January of the first funding for the present emergency plan with the Global AIDS Fund, which became operational over one year ago. This means that there is more money available for working on AIDS than ever before.

But there is still an enormous funding gap and we also have to look at that. I am usually someone who believes the glass is half full but that means definitely that the glass is half empty as well, and in that sense the best way to make sure that this funding is not only sustainable but also increases will be two-fold. One is showing results, showing that the money that is available today is used well and reaches those in need to save lives. And secondly, that public opinion in all countries is far more sensitized to the AIDS issue than ever before and that includes other countries where HIV is not an acute problem or where most people have access to life saving treatments. In other words, that complacency about AIDS is eliminated.

Secondly, and that is probably the most important factor, is making the money work. It is a problem of **capacity** in many cases where greatly increased financial resources and political commitment are not yet matched with the availability of human and institutional resources. That is the top challenge for many countries. And I have visited during the last six months countries where literally hundreds of millions of dollars are being allocated for AIDS, but the institutional capacity has been neglected. Some of it is the result of decades of undermining of the state by the government itself, by international institutions, and by the donors. We are paying a high price for that. Some of the decreasing capacity has to do with the epidemic itself because professionals are dying from AIDS and also professionals in many countries do not have access to antiretroviral therapies. So we need to make sure that in our current funding not only are the projects funded, but that we have a comprehensive approach and that no project should be approved if there is not a strong capacity building element in the funding itself. So let us not ask for the first results after the first trimester. If we do not invest in capacity, and we do not rethink some of the policies that undermine capacity, particularly in the public sector, there is no way that we will succeed in our fight against AIDS.

On the other hand, when it comes for example to accelerating access to treatment, there is still a lot of capacity that is not used, particularly in the major cities and in existing institutions that are already seeing hundreds of thousands of patients. The same is true for prevention. A report that we will issue on the 6<sup>th</sup> of July before the International Conference for AIDS in Bangkok will show that coverage of prevention services throughout the developing world is very low and we are not making use of large organizations such as existing school systems and the workplace to reach those people who can be saved by access to improved prevention efforts.

The third challenge is that we have still not collectively accepted the exceptionality of AIDS: that it will not be possible to contain this epidemic and to overcome all its aspects in terms of prevention, treatment, care, if we are going to simply allocate resources from the normal budget and respect all the rules of the game. It is not going to be possible in the most affected countries. It will be possible I hope in those countries, particularly in Asia and in Eastern Europe, where the epidemic is still in its infancy. There it can be done by introducing good policies and allocating resources from existing budgets. In the most affected countries, particularly in Africa, this will not be possible. This is like a situation that is comparable to post-conflict where an extraordinary effort has to be made. That is of course true at the individual level and when it comes to the disease itself because of the enormous stigma and discrimination that is associated with HIV and with the enormous gender dimension. Therefore I am not one of those people who believe that even if everybody would be treated for HIV that the stigma would disappear suddenly.

We need specific campaigns and efforts to eliminate the stigma and discrimination of AIDS. We are still seeing it in the countries in Western Europe where treatment access is universal. It is not a disease like any other. I do not know of any person who says with diabetes you will be

beaten to death because of the diabetes. So let us not be naïve about what the very necessary access to treatment would achieve when it comes to the nature of the disease and of the epidemic.

But we also need to look at policies. For example sometimes I hear that the extra funding that is coming in for AIDS cannot be spent because of a medium-term expenditure framework or fiscal ceilings, which are there and have a good reason to be there. They are necessary to control inflation and soaring inflation and hyperinflation, which affect the poor in the first place. But when controlling inflation hypothetically becomes more important than accepting the resources to control AIDS to save entire societies I know that something is wrong in our priorities. That is why it is necessary to have a good dialogue and better understanding of the fiscal implications of the global trade rules which have been adopted because there is an AIDS epidemic, and financing and fiscal modalities should reflect that.

Fourth, we have a new challenge and that is one of coherence and accountability. The good news is more money, more actors, more players, but as we will hear from about every country report today, many countries are struggling with making sure that all the actors are working to implement the countries' priorities. And frankly it is pretty much chaos in some countries. Not in the ones that are here today because they are outstanding examples of leadership by the countries themselves. Soon our board will meet and we will issue a report showing the price of fragmentation and lack of coherence.

A lack of harmonization really kills people. We see that some countries had to cope with 60 different AIDS missions in one year, and sometimes we in the UN system are as guilty as anybody else. And that is why I have been working very hard on the principles of the **Three Ones**<sup>1</sup> which have now been accepted and signed by all donors except for the European Commission. **First**, to work under one agreed AIDS action framework ensuring there is ownership on the country level and that everybody works for the country's priorities. **Second**, that we work with one national AIDS coordinating authority with a broad based multisectoral mandate. That reduces duplication but leaves at the same time the space for every player to work. And the **third** one is that there is one agreed country-level monitoring evaluation system to reduce transaction costs for all concerned. I have seen too often that the small members of staff in an AIDS program spend most of their time not only receiving the missions but also filling in forms for each donor with a different monitoring evaluation form. So if we can all work under these principles, not only will we have a better ownership but also better accountability and at the end more reserves and better use of taxpayers' money.

And the last point I would like to bring up is that we have learnt that there is a need for a truly comprehensive response to AIDS. Most countries until recently have only focused on prevention, some have only dealt with treatment and therefore have been able to avoid the difficult problems and issues related to sex and drugs. But the only thing that will work is a

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<sup>1</sup> At the International Conference on AIDS and STIs in Africa (ICASA) held in Nairobi, Kenya, in September 2003, officials from national coordinating bodies and relevant ministries of African nations, major funding mechanisms, multilateral and bilateral agencies, NGOs and the private sector gathered for a consultation to review principles for national-level coordination of the HIV/AIDS response. The principles were identified through a preparatory process at global and country levels, initiated by UNAIDS in cooperation with the World Bank and the Global Fund to Fight AIDS, Tuberculosis and Malaria and have been further refined in dialogue with other key donor partners :

- **One** agreed HIV/AIDS Action Framework that provides the basis for coordinating the work of all partners.
- **One** National AIDS Coordinating Authority, with a broad based multi-sector mandate.
- **One** agreed country-level Monitoring and Evaluation System.

comprehensive response to AIDS. Some studies that we will announce right before the conference in Bangkok demonstrate how treatment programs without a strong and accelerated prevention aspect will not be sustainable, but also that they will become better with better prevention and thus worthwhile.

So let me basically stop here and say that I am really proud that we are associated as the joint **United Nations Program on HIV/AIDS with the World Bank's work** because I think there will be some original aspects, and the Bank has started addressing the exceptionality of AIDS. **First**, the development of an original lending and all grant instrument, for the multi-country AIDS program, which is not business as usual in the Bank. **Secondly**, it is pioneering a new funding mechanism to make sure that money goes directly to local authorities and can go to community-based programs. And **thirdly**, also to accept to participate in pool funding arrangements. I was in Malawi when it was decided that the Multisectoral AIDS Program (MAP) funding in Malawi should be joined with funding that comes from other donors. I think it is a very good example. But I believe that there is still a lot of work to do, that AIDS is still not included in some of the main work of the Bank, and certainly not of the IMF in its macroeconomic work and its macropoverty work in the PRSPs (Poverty Reduction Strategy Programs). And this is where all of us have to work together.

The countries that we will hear from are in themselves outstanding examples of leadership and of having found innovative solutions for their problems. Frankly, they have done it on their own, in some cases with a lot of funding from the outside, but in all of them it has been driven by the local leadership and the local adaptation to the challenge. I think what we should now focus on is learning from successes, or rather from some very positive experiences that can be used by all countries, since there is no real success in defeating AIDS. We, in the UN system, can be facilitators in sharing that experience throughout communities and countries.

### *Joseph Ingram – Introduction of Speakers*

Thank you, Peter. Before turning the floor to Ms. Grunitzky-Bekele, let me introduce our panelists today. They include, from Brazil, the Director of the National STD/AIDS Program, Dr. Alexandro Grangeiro; from Senegal, the Executive Secretary of the Conseil National de la Lutte contre le SIDA, Dr. Ibra Ndoeye, and the Deputy Executive Secretary Madam Katy Cisse Wone; from Thailand, we have the Director of International Health Policy Program of the Ministry of Public Health, Dr. Tangcharoensathien Viroj, and the Chief of the AIDS Cluster from the Ministry of Public Health, Dr. Somyot Kittimungkong; and from Uganda, the Director-General of the National AIDS Commission, Dr. David Kihumuro Apuuli, and the Program Manager of the STD/AIDS Control Program in the Ministry of Health in Uganda, Dr. Elizabeth Madraa.

Our moderators in addition to myself and to Ms. Meskerem Grunitzky-Bekele, include for this afternoon's panel discussion and follow-up, Dr. Michel Kazatchkine, Director of ANRS, France, and one of today's leading experts on the disease. The wrap-up and conclusions will be done by Dr. Gottfried Hirnschall, Director, Partnerships, External Relations and Communication, HIV/AIDS Department at the WHO and Brad Herbert, Director for Strategic Development at the Global Fund for HIV/AIDS. As you can see, we have a distinguished group of people here who do understand the problems and who should be able to help us in drawing out some interesting and hopefully useful conclusions this afternoon.

***Ms. Meskerem Grunitzky-Bekele, Chairperson of Morning Session***

Ladies and Gentlemen, it is a pleasure and an honor for me to chair the first session of this symposium. I want to start by reminding everyone of the objectives of today's sessions.

First is to hear from the people who are in the field, the people who are actually following day by day the programs at the country level and to learn how they have developed a comprehensive program at that level. We refer not only to health aspects but also to the non-health aspects.

Second is to learn from them what are the main obstacles for implementation, what are some of the major factors for success or progress, and also to identify with them what will be the future challenges, what recommendations they are proposing and how they want to deal with those challenges. We want to know from these presentations the common policy or common actions that have led to success or failure. So it is really a session to learn from country-level experiences.

The first presentation is from Brazil. I want to introduce Alexandro Grangeiro who is the Director of the STD/AIDS Program in Brazil within the Health Ministry. He is a sociologist and a public health specialist. As Brazil is a focal point for the technical cooperation group for Latin America and the Caribbean, he is also involved in promoting this collaboration, which is one of the reasons for the success of that region. He is also a member of the UNAIDS board for Latin America. The second presenter is Dr. Ibra Ndoye from Senegal, who is currently Executive Secretary of the National AIDS Council. Dr. Ndoye has been the Manager of the National AIDS Program in Senegal since 1986. He has also contributed to the fight against HIV/AIDS in the whole of Africa. He was the original Director of the International Union Against Sexually Transmitted Infections and also President of the African Union against STI. He has engaged in a lot of research and is also the author and co-author of more than one hundred publications. Our third speaker is Mme Katy Cisse Wone, who is currently the Deputy Executive Secretary of the National AIDS Council, in charge of civil society and the private sector. Before that, she was Technical Adviser within the Ministry of Health in the area of HIV/AIDS. From 1991 to 2000, she was a National Expert with the International AIDS Program working with UNDP and WHO, and before that a Program Manager for HIV/AIDS projects. So we will have a real country experience from these speakers. They are outstanding models for leadership with high level commitment, both political commitment but also social mobilization to address the challenge of HIV/AIDS.

So now I will call Dr. Alexandro Grangeiro, from Brazil.

***Presentation by Dr. Alexandro Grangeiro, Brazil***

Ladies and Gentlemen:

On behalf of the Ministry of Health of Brazil, I would like to congratulate UNAIDS and the World Bank for today's event. It is an excellent opportunity to exchange experiences we've had in different countries, but also to create opportunities and to translate them into concrete actions that could stop and reverse the spread of AIDS.

Today I will speak about the Brazilian response to AIDS, focusing on some of its unique characteristics. My presentation can be divided into three parts: The first one is related to the

structure of our response to AIDS and some factual data. The second part deals with actions taken to promote health and to assist people with HIV. And finally, I'd like to focus on the experience we've had with cooperation.

I will first try to highlight those factors that have defined and facilitated the Brazilian response to HIV/AIDS before talking about those aspects that continue to remain our major challenges.

### ***Country Profile***

As you know, Brazil is a country of large dimensions: 170 million inhabitants and some 6000 districts. We had our first case of AIDS in 1980, and since then we have had 300,000 official cases. That is a ratio of 12.8 cases per 100,000 inhabitants. Prevalence rates have decreased in recent years. We now have an estimated 600,000 people infected with HIV, which is equal to 0.6 percent of the population aged 15 to 49. We have an estimated 30,000 to 35,000 new infections every year. Regarding mortalities: we've registered 150,000 AIDS-related deaths, which is 11,000 deaths per year, or a mortality rate of 6.3 per 100,000 inhabitants. The reason why mortality rates have decreased in recent years is because access to essential medicines has increased, which has also had a positive impact on life expectancy.

### ***Characteristics of the Brazilian Fight against the AIDS Epidemic***

Which aspects can we attribute our results to?

First of all, the Brazilian response to HIV/AIDS was an early one. We launched it in 1983 when there were only four cases. Second, at the very outset we saw substantial engagement on the part of the general public. They participated not only in the setup of our assistance and prevention programs but also in the process of managing public policy, which was developed at all three levels of government: at district, state, and federal levels. A third aspect that characterized our response was that we sought a global, multisectoral approach beyond the public health sector to involve the private sector, international organizations, universities, the judiciary, social institutions, and others. A fourth critical aspect we should not underestimate was our country's national culture. It led the Brazilian people to show solidarity with those living with HIV and allowed us to discuss openly taboos such as sexuality, drug abuse, or extramarital sex. Fifth, an important part of our response was to promote treatments. We're convinced that we had to guarantee universal access to health services and therapies. And finally, what made all the difference in our fight against HIV is the ethical component of our response, which promotes human rights and defines access to health care as a duty of the state.

### ***Organizational Structure -- Decentralization***

It is the responsibility of the Ministry of Health to coordinate and harmonize the activities of the different sectors, institutions and actors involved. To live up to this responsibility, three commissions were created.

The first, which is linked to the Ministry of Health, is called the National Commission. It is composed of both governmental and non-governmental actors who coordinate activities on the national level. The second commission represents districts and states with the aim of decentralizing our strategy "in the field." The third commission deals with society and social movements. It seeks to harmonize governmental and non-governmental activities, but also to incorporate societal concerns into public policy.

I would like to draw your attention to two bodies that are absolutely essential to our national strategy. One is the UNAIDS theme group. It has an amplifying effect in that it brings together all major bilateral and multilateral institutions that have a presence in our country, and it is the main contact for international organizations. The other body is the Business Council (Conselho empresarial). Its job is to unite unions and corporations which are developing activities to combat HIV and AIDS.

Of utmost importance to our efforts is the decentralization of our response in the country. States and districts are responsible for the execution of our health programs, for both assistance and HIV prevention. 45 percent of our federal resources are transferred to 27 states and to 411 districts. They were selected based on the number of registered incidences of HIV/AIDS. By focusing on these districts, we were able to target 90 percent of all AIDS cases and cover 53 percent of the Brazilian population. The allocation of resources to the districts is based on an annual action plan, which is worked out jointly by the government and civil society organizations. This plan is monitored by the federal government.

### ***Financing***

Our country spends about 250 to 260 million USD per year on activities related to fighting HIV, with resources being allocated at the federal level and managed by the Ministry of Health. There are two main sources of funding: 90 percent of the resources come from national funds, the final 10 percent come from World Bank loans. The first agreement reached with the World Bank dates back to 1994, and we are currently in our third agreement with the Bank, which is expected to end by 2006. Of these resources, 60 percent are for expenses on medicines, 15 percent for prevention, another 15 percent for assistance, and 10 percent for related research, training, and management of the program.

### ***Monitoring and Evaluation***

First, in order to execute our policies in Brazil, we created the so-called “Stein” phase, a national system of monitoring and evaluation that harmonizes research results, health training systems, and specific evaluation indicators devised under the national program, especially in the areas of prevention, assistance, and human rights. There are now five regional evaluation centers. We continue to harmonize their activities and to seek international cooperation on these issues in view of creating an international AIDS services center that provides training and evaluation. We would also like to set up a committee comprised of the principal institutions and professionals involved in evaluative assessments in our country.

### ***Anti-AIDS promotion and Prevention of HIV/AIDS in Brazil.***

On promotion, Brazil has developed several complementary actions in four areas: first, by promoting the rights of individuals living with HIV/AIDS and of high-risk groups through national media campaigns. We have launched three nationwide campaigns directed at the general public and a number of campaigns targeting specific groups. These two national campaigns are further complemented by measures developed at the community level. Fourth, we have specific campaigns to promote diagnostic measures and the treatment of sexual diseases.

## *Results*

From the start of the epidemic, Brazil had a policy of promoting the use of condoms. We recognized that it was the responsibility of the state to inform its citizens about sexually transmitted diseases, particularly HIV/AIDS, and to offer ways of prevention. By implementing such actions, we were able to see an increase in the use of condoms, which today is about five times higher than ten years ago. Free distribution of condoms has increased by 20 percent, and the Ministry of Health oversees about 30 to 40 percent of that distribution. This has markedly reduced the prices for condoms.

Another effect we can attribute to condom-promotion policies is related to sexual behavior. International researchers point out that among those who engaged in sex with occasional partners, the use of condoms increased from 64 to 79 percent over the last years. This increase is significant in light of our efforts to control the spread of HIV/AIDS. The same results were not observed among those who engaged in sex with regular partners. Among the latter group, the rate of condom use remained constant at about 20 percent.

We should note that in Brazil the increase in transmission rates among females is significant, especially among women in steady relationships. This remains a huge challenge for us, and we are currently reviewing our prevention policies vis-à-vis couples and those in stable partnerships. To support our prevention efforts among women, Brazil has adopted a policy for the distribution of condoms to females. About four million condoms are now distributed annually, especially to four groups: women living with HIV/AIDS; sex workers; drug users and their partners; and female victims of violence.

In addition, Brazil has adopted a policy of prevention for drug users, which promotes the use of clean needles. Such programs also involve the support of public institutions and NGOs. The effectiveness of these projects is reflected by a reduction in the multiple use of needles and fewer cases of AIDS and Hepatitis C. I should note that drug users are a group that is highly marginalized and that their insurance coverage is very low at about 20 percent.

Further to our prevention strategy, we must also focus on promoting early diagnosis. We estimate that 300,000 to 400,000 people in our country today do not know they are infected. Often, the diagnosis is not made until four or five years after the infection. To counter this, we launched a massive campaign to promote diagnostic testing. Our slogan: “Know It, Positive or Negative. Be Happy!” This campaign has led to an increase in diagnostic testing from 30 to 40 percent in Brazil.

As a result of a combined prevention policy that promotes the use of condoms, urges drug users to use clean needles, and advocates early diagnosis, we have seen a reduction in prevalence among those most exposed to the risk of HIV/AIDS, such as homosexuals, workers in the sex industry, and drug users.

Finally, a few words on the promotion of health.

Regarding the prevention of mother-to-child transmission of the disease, Brazil has established prevention measures during the prenatal and maternity phases by expediting procedures from test to diagnostic of HIV and by providing prophylaxis with antiretroviral treatments. Even though in the last few years coverage has increased considerably, by about 15% in the past year alone, only 40% of pregnant women who are HIV positive have been diagnosed and treated. We estimate there are about 17,000 infected pregnant women in the country. Due to the use of

prophylaxis, the rate of mother-to-child transmission of HIV has decreased from 16 percent in 1998 to 3.7 percent today.

On the issue of **health care**, let me emphasize that Brazil has been making great efforts in this area for several years now.

Since the 1980s, Brazil has been mobilizing a range of health care resources in different regions from basic services, such as diagnostics, to more complex services associated with hospitalization. The country has also established a system of laboratories (pharmaceutical producing companies) for viral and CD4 testing (cell count to determine the level of function of the immune system), which is currently expanding its focus to include genotyping and research in viral resistance. Since 1996, the country has guaranteed access to antiretrovirals (ARV), which includes 15 different drugs. The latest additions to this list are Atazanavir and Tenofovir. Government-owned laboratories produce seven of these 15 drugs.

These healthcare policies have brought about important results for the country: a 50 percent reduction in mortality rates, or 90,000 deaths between 1996 and 2002; a 70 percent reduction in the cases of tuberculosis; and fewer numbers of cases in which hospitalization was necessary to treat HIV/AIDS, which has led to decreased demand for complex services. In 1996, the annual rate of hospitalization was 1.65 per patient. By 2003, this rate had dropped to only 0.25 per patient. During that period, we prevented over 630,000 hospitalizations. Also, we saw a considerable increase in the number of surviving patients. A projection study from 1996 to 2002 shows a survival rate of 58 months.

A national study of 3,000 randomly selected patients showed that of the 95 percent who were monitored over three consecutive days, 75 percent complied with the ARV therapy that was being administered. This is compatible with other countries that have promoted universal access to treatment. Compared to other countries, resistance to treatments is low in Brazil, probably due to the Brazilian approach of a less invasive treatment and measures for HIV/AIDS prevention.

The biggest challenge we face in our efforts to provide access to treatment is related to the sustainability of our policies. This is especially the case in the acquisition of antiretroviral drugs. The purchase of imported drugs takes up 63 percent of our budget. The lion's share of that falls on three particular drugs, while the remaining 12 drugs, especially those produced nationally, take up only 37 percent. Thus, Brazil follows three strategies to reduce the price of drugs and to keep purchases sustainable.

First, at the international level, Brazil advocates more favorable terms for developing countries to acquire affordable medicines, keeping public health interests above international agreements, as spelled out in the Doha Declaration. Second, our country maintains a system of national laboratories that produce antiretrovirals, which has reduced the price of seven drugs by over 36 percent. Third, we negotiated with laboratories to eliminate drug costs worth 99 million USD in 2004. After negotiations, some prices were reduced by 75 percent.

These three strategies have helped Brazil keep costs stable over the last three years, despite an increase in the number of patients being treated with antiretrovirals. Every year, 16 to 20 new patients are treated with antiretrovirals. Our projection is that by the end of 2004 we will have 148,000 patients receiving treatment in the country, with costs of approximately \$1,630 per patient, as opposed to \$5,000 per patient in 1997.

To sum up, the combination of these cost-reduction measures has enabled Brazil to avoid costs of about \$2.4 billion, mainly by reducing hospitalization rates and lowering prices for drugs. In the last two years, what we save in hospitalization is similar to what we would spend in antiretroviral medication. Therefore, we have a good cost-benefit ratio when it comes to promotion of access to medication in Brazil.

### ***South/South Cooperation***

To conclude my presentation about international cooperation, I should add that Brazil follows a strategy of cooperation in four ways. First, by promoting solidarity among countries of the South – we currently cooperate with 14 countries by providing treatment with Brazilian drugs. Second, by facilitating technical assistance in our region through a technical assistance network for Latin America – for the establishment of this network, we adapted the methodology used by UNITAR in order to identify the demands for technical assistance. Third, by adopting the proposal to establish a network of technological exchange among seven countries, which will be established in a Letter of Agreement in Thailand – the objective of this agreement is to share experiences in the development of production of medications and vaccines. And finally, by setting up a database of international prices for antiretroviral drugs.

### **Comments by Ms. Meskerem Grunitzky-Bekele**

Just to summarize the first characteristic of the response in Brazil: I think you have described very well what the structure was. The National AIDS Program is within the Ministry of Health, and it is coordinating the other sectors; but it also has a system for working with civil society and, within the sectors, has a Commission to harmonize the work of the ministries. You have also presented us with how the decentralization processes work and how resources are allocated based on this decentralization, which was important for the support of civil society. And finally, you pointed out that 50 percent of resources were given for activities through presentations of proposals. It was also interesting to see that national expenditure has been divided by thematic areas, with 60 percent for example for antiretroviral treatment, 15 percent for prevention, 15 percent for support to patients, and 10 percent for research and training. The monitoring and evaluation plan that you are developing sounds interesting.

The second part was on health promotion and prevention. You have presented the strategies that you are using and also some key results about condom use and also access to HIV diagnosis and the impact of the prevention for vulnerable populations.

The third part of your presentation focused on access to treatment, and one important thing is that access to treatment is guaranteed by law in Brazil. The government has made successful efforts to produce drugs locally and cheaply, and you have given key results of this policy for Brazil. The last section was on how you have developed international cooperation. Now we will allow time for focused questions and deeper discussion.

### **Questions for Alexandro Grangeiro**

#### ***Q. International Labor Organization***

The ILO has been working with Brazil for a long time. I would like to ask about the costs you mentioned that you have saved with the Brazilian programs. Do you have a figure that also shows the socio-economic costs that have been prevented, meaning absenteeism and reduction of the labor force, and also savings in social benefits like pension funds, social disability and so on?

A. Certainly the costs we have saved are enormous, but I don't have figures with me.

***Q. International Organization for Migration.***

Brazil of course is known for universal free access to treatment. But does this include people without health insurance? And does this include people without legal status in the country, especially people in transit in the country? If it does include access for people in transit, have you noticed people coming to Brazil to gain access to treatment?

A. The Brazilian government has opted for the principle of universal treatment. This means that it will include all people in need of treatment, irrespective of insurance issues. There are leakages from neighboring countries and a consequent request from the regions closer to the borders. We try to provide treatment to these people according to our capacity and we often establish agreements with neighboring countries.

***Q. International Bureau of Education (UNESCO)***

I wonder if you could develop a little more how other sectors are included, especially at the government level, in the ministries, and how you managed to set up a real cross-sectoral or inter-sectoral response at the government level, including especially social affairs and education. As you mentioned, the education sector is hurt by the epidemic in terms of staff and resources.

A. Our cross-sectoral approach includes a strong involvement of education-related institutions. We involve local councils and schools both in awareness programs and distribution of condoms.

***Q. Program on Public Health, University of Geneva***

I have two short questions. The first one is how do you work with human rights-based NGOs? You mentioned it was a very important issue. And the second is an emerging issue, and it could be addressed to all countries but especially to Brazil. How do you work with religious leaders and religion, especially in light of the conflict that the Church and the Vatican pose on all reproductive health issues?

***Q. AIDS Feedback, Geneva***

I had the chance to observe the Brazilian Development Program over the last 15 years, and I was indeed impressed. This success story of course should be written up in light of the relationship with the Roman Catholic Church. So it would be nice if you could mention what the work relationship has been with the Catholic Church.

A. ***To these two questions:*** Our human rights-based approach implies that we work closely with several categories of NGOs, including human rights NGOs. They are especially involved in the monitoring of AIDS-related human rights violations, legal advice on access and treatment, and labor rights. In relation to the involvement of the Catholic Church, Brazil has experienced great support from Catholics as well as from other churches. The Roman Catholic Church does not represent the majority in Brazil, and other religious actors have made important contributions. Brazil has experienced a certain resistance from the highest ranks of the Catholic Church, especially on condoms, but at the grassroots level the involvement in fighting the epidemic has been exemplary.

## **Presentation by Dr. Ibra Ndoeye, Senegal**

### ***Country Profile***

First of all, let me speak about my own country – in the context of HIV, Senegal is a small West African country with a very religious population (95 % Muslims and 4 % Christians). Even though it's a staunchly religious country, there's a lot of tolerance. We've been one of the first countries to intervene in the practices of sex-workers. Prostitution has been legalized, and religious people tolerate the promotion of condoms. We began monitoring HIV in 1988. What makes Senegal a special case is that we've been able to keep the prevalence of HIV constant at 1 percent of the general population with HIV 1 and HIV 2.

### ***Period from 1986 to 1999***

In the first instance, we tried to define the strategy used in Senegal and looked at two periods: one from 1986 to 1999 and the other from 2000 to 2004. During the first period, we coordinated the HIV/AIDS programs with the Ministry of Health. As in the case of Brazil, we conducted programs in collaboration with other sectors, such as the education sector and those sectors working on women's issues. During the second period, which included the Longas Summit in 2001, countries were asked to show leadership at the highest levels of government. Since then, coordination efforts in the fight against HIV/AIDS have been elevated to the Prime Ministerial level.

During the first period from 1986 to 1999, which marked the beginning of the epidemic, medical interventions were of particular importance. But may I remind you that the treatment of sexually transmitted diseases had been in existence in Senegal even before the AIDS epidemic. We already had in place a strategy of paying for STDs, blood safety examinations and opportunistic infection treatments, and of giving guidance to patients. In terms of behavioral changes, we had lots of interventions in the general population until 1990. But then we started to talk more about focused interventions – particularly for young people and women. Most importantly, we began to target schools and those engaged in prostitution. Since 1989, even before the existence of UNESCO strategies, we've been actively introducing HIV/AIDS programs in schools, and are presently administering examination programs.

Initially, it wasn't easy to promote the use of condoms in such a religious country. However, over time we increasingly received support from religious leaders, first from Catholic leaders and then from leaders of the Muslim community. We were even able to forge an alliance between the two religious groups in a joint campaign against HIV/AIDS. And we brought them together with medical experts. Now, we have information leaflets on the use of condoms which include verses from the Koran and citations from the Bible. We promote the use of condoms, and as a result the number of condoms distributed has increased from 500,000 in 1988 to 6 million in 1996 and up to 9 million today.

Another important factor in our campaign against HIV/AIDS has been the leadership we received at the Presidential level. In 1986, when we first met with our President to talk about HIV/AIDS, he said he fully supported us and told us he would enact our propositions. And the current President has shown the same kind of engagement. In fact, he asked for our advice even before he came into office. He is very active and follows the advice he receives from his experts. Consequently, he has increased the budget for antiretroviral treatments. So we can say that there has been continuity in the policies of our leadership.

An important part of our strategy has been a process of monitoring and evaluation. We knew from the outset that it would be impossible to fight HIV/AIDS otherwise. So we needed surveillance and evaluations. In addition, we put enormous effort into our operational research and prevention programs. In the eighties, we worked with our friends from Kenya and with IMT to better understand the linkages between HIV/AIDS and other sexually transmitted diseases. You may remember the Tanzanian example in which we demonstrated that, with an appropriate treatment, it was actually possible to reduce the number of HIV/AIDS cases by 42 percent.

We also conducted some fundamental research on antiretroviral treatments in close collaboration with the National French AIDS Research Agency, and I can say that lots of people didn't believe in this undertaking at the time. I'm happy to see that today lots of institutions support antiretroviral treatments. Convincing them was still a challenge in 1998. UNAIDS did a study on antiretroviral treatments in Uganda and Brazil, but we initiated the first governmental research project that demonstrated the tolerance and feasibility of such treatments. With the support of UNAIDS, I represented my government in the first negotiations we had with firms from Egypt. As a result, we saw a 90 percent increase in antiretroviral treatments in African countries. It's important to talk about these results because some people were not willing to embrace this approach. We had to meet with Michel Kazatchkine, UNAIDS and the WHO before we were able to issue a document that introduced antiretroviral treatments.

The related question was about how to develop a successful global strategy. We found the answer to this in Senegal. The first case of HIV appeared in 1986. In response, we created the National AIDS Committee in October 1986. This was before 1987 when Jonathan Mann and the WHO asked countries to create national committees. From the beginning, we had the full support of our Head of State and our Head of Government. With the support of France, we set up a budget in order to control the safety of blood supplies within our national territory. This was important because we were of the opinion that the government should live up to its own responsibilities first before telling people to protect themselves from AIDS. Unfortunately, until 1992, 80 percent of African countries were not providing the same levels of blood safety standards.

Early on, we believed it was necessary to increase our efforts. We had medical experts to help us, but we also wanted to include civil society and religious leaders. At no point was this an easy task, but in the years 1992 to 1994, we were able to organize a pan-African meeting designed to improve relations between governments and civil society. In order to achieve this, we simply could not exclude religious groups and schools from the debate.

Another important factor in our campaign was ensuring continuity in our management approach. We've been managing the strategy against AIDS as a team since 1986, and when new people join us we make sure to provide continuity in our overall approach. In Senegal, we didn't have a huge turnover in program managers because we had enough money available. I believe people should only be asked to leave when there are not enough funds. So for us, maintaining management continuity is of great importance.

In coordination with UNDP, civil society, and national governments, we set up a partnership forum in 1988 called the "Mixed Partners Commission on AIDS". Some years after we, together with UNAIDS, had established expert groups for the different topics that were being covered, we proposed that UNAIDS be a dynamic contributor to this partnership forum. And today we are heavily involved in the Global Fund Country Coordinating Mechanism (CCM),

which focuses on three diseases: tuberculosis, malaria, and HIV/AIDS. In addition, we work with national AIDS committees. However, we often ask ourselves: should we have a special CCM as an integrated part of these national committees and health ministries? After all, when we think about intervention mechanisms, we need to remind ourselves to adapt them to circumstances at the country level because what works for one country doesn't always work for another one.

### *Second Period – from 2000 to 2004*

Now I turn to the second period from 2000 to 2004, during which we held the Longas Summit of 2001. By then, we were able to get access to antiretroviral treatments, which was a new thing for Senegal. Patients now have access to such treatments, and we are thinking about initiating a comprehensive program that would allow for voluntary counseling and testing as well as for mother-to-child transmission prevention strategies. Up until now, this had been impossible because we were simply not able to offer anything to those people who had been identified as HIV-positive. In addition to ICC/CCC interventions that were designed to prevent STIs, we developed a mother-to-child transmission prevention strategy based on a first pilot study. Now we are in the scaling-up phase, and three regions already offer such prevention programs. As for voluntary counseling and testing – we launched such testing in 2001 for the first time, and now there are ten centers that offer it. Because the government was a bit late to implement these programs, several NGOs took matters into their own hands, so that most of these centers are now managed by NGOs. We've decided to implement voluntary counseling and testing in a total of 45 laboratories by the end of the year.

Speaking of access to treatments – thanks to the personal commitment of our Head of State, free access to antiretroviral treatments has now been available since January 2004. The state budget was increased from 500,000 USD in 1988 to 1 million USD in 2000 and to 1.5 million USD in 2001. It now stands at 2.3 million USD. In addition to our own efforts, we also benefit from the support we receive from the World Bank for projects and medicines, and from the Global Fund.

There are both challenges and risks associated with the HIV/AIDS epidemic. But if we hadn't taken the risk to offer antiretrovirals and show concrete results, treatments wouldn't be accessible to all countries today. Also, discussions such as this one can lead to other declarations, which will make Heads of States aware of their responsibility to get engaged and to get their governments to manage the implementation of these treatments. Opportunistic infection treatments are already paid by the state. We have a separate group working on monitoring and evaluation. While all partners involved have their own individual coordinating groups, we have one coordination plan that everybody uses. It's also important to ensure that we get continuous political support from the Head of State and the government, so that we can continue to enlarge our responses in all sectors. But what we can say about our multi-sector approach is that we now have plans in place for the most vulnerable sectors: the education and health sectors, for our youth, families and women, the army, workers, and civil society at large, with funding from the World Bank.

### *Scaling Up*

We believe it is important to get leadership support not only at the political but also at the community level in order to scale up and decentralize treatments and prevention programs. Because if they are not functional at the operational level, then it is more difficult to see any impact. A regular evaluation process is also an important element of our strategy.

Major obstacles arise when there is a conflict among the leadership, especially between the medical community and other sectors. Since the medical community laid a claim on the topic of AIDS early on, some conflicts arise when other sectors get involved.

Another sticking point is that epidemiological data is often insufficient, particularly for very mobile and migrant populations. We conducted a pilot study in order to validate the results for mobile populations. We also have strategies in place for prostitutes and homosexuals, but we need to be careful and discrete in the prevailing religious context.

### ***Lack of Capacity***

A further obstacle is our shortage of medical workers. With all the different treatment and access programs we have in place, there's currently a work overload. Some of our doctors leave us to work for international organizations because they pay more. But we also lack commitment from the private sector. We can say that we are advancing steadily, but we still have some delays that we are trying to compensate for.

Stigma and discrimination are further obstacles that hinder our efforts. But with access to treatments now available, HIV associations have become much more visible. Not only do they promote strategies such as CDV and mother-to-child transmission prevention, but they can also effectively help in the fight against stigma and discrimination.

### ***Conclusion***

Summing up, factors that contribute to our success are: first, a multisectoral and enlarged response, which should be based on partnerships between civil society and religious leaders as well as between the medical community and other sectoral actors such as the Ministry of Education, Family and Youth. At the same time, we must ensure continuity in our approach because otherwise the epidemic will keep on spreading. Second, we need medical treatments for STI and blood safety, whereby it is essential to have well trained medical staff and free access to antiretroviral treatments and testings. We should extend such free access to CD4 and viral charges. I heard that the price of a treatment in Brazil was 1,600 USD a year, but I think that in Senegal, prices for a tri-therapy including CD4 and antiretroviral varies between 500 and 1,000 USD a year. Finally, operational research is fundamental to our efforts. This is why we cooperate with our friends from the INRS and other institutions.

### ***Presentation by Mrs. Katy Cisse Wone, Senegal***

The major challenges we face have to do with finding ways to overcome the hurdles that Dr. Ndoye mentioned earlier. The major obstacle is, of course, the decentralization and scaling up of our efforts. In other words, how to transform the different pilot experiences we had at the central level and replicate them to cover the whole national territory. Implementing the whole range of activities related to treatment and care now constitutes a big challenge to Senegal. Today, access to antiretroviral treatments covers most regions. The mother-to-child transmission prevention program hasn't reached the ideal level yet, but we are in the process of decentralizing this service.

Voluntary counseling and testing continues to be a major challenge especially due to low prevalence rates. It raises the question of how best to encourage individuals to get tested when they don't really feel the urgency to do so. They often rationalize that, with a prevalence rate of

just 1 percent, they aren't at risk of being one of those 1 percent. We continue to encourage people, but I think that people are overall still reluctant to get tested, and this is one of the major obstacles in Senegal. Of course, we can provide test centers, but people still have to visit them. So the actual rate of voluntary testing needs to increase in order for us to bring down the number of patients who show up with symptoms of the disease.

We also need to define effective communication strategies. Since there was no existing therapeutic response to HIV/AIDS, it was difficult to promote voluntary counseling and testing. We still need an effective communication policy to promote the availability of ARVs. And above all, we need to communicate the advantages of being aware of your serological condition. As for the issue of care, we need to address the problems that people with HIV encounter, such as nutritional problems and the difficulties of finding and exercising income-generating activities.

The other major challenge is prevention. We've had a policy focused on prevention and on care. Senegal's success is actually based on a good balance between these two issues. But concerning prevention, the challenge is to create a response at the community level, including in the most remote regions of Senegal which have so far not seen any interventions in the fight against HIV. This is why we will place a major emphasis on targeting rural communities. Sixty percent of the population live in rural areas, so it is crucial to direct our efforts to these rural areas and define strategies that provide access to the local populations.

And when we look at the distribution of Senegal's available funds, we should feel encouraged to focus more on rural areas because 65 percent of our resources go to the community level, while only 15 percent of our available funds are allocated at the national level and 20 percent at the regional level.

When we talk about getting a community response, we need to focus our efforts on working with basic local community organizations: the NGOs, women's associations, youth associations, etc. In Senegal, we have a very dense network of associations, and that network has been in existence since the first years of independence. This network of associations was established under President Senghor, and what we did was to direct the dynamics of an already existing social and political fabric to the fight against HIV.

So today the challenge is how to bring together all development organizations, such as the farmers and cultural associations, to fight collaboratively against HIV/AIDS. Of course, not every organization can specialize in fighting HIV/AIDS, but I think that there's an appropriate expression in English that captures the essence of what is needed, which is "mainstreaming." How to get these associations to integrate the fight against HIV/AIDS in their daily activities? As this is one of the major challenges we have, we try to interact directly with all of these basic organizations as much as possible.

As already mentioned, it is a major challenge to implement voluntary counseling and testing on a large scale. There's a study that was recently published, which Dr. Ndoye mentioned earlier. It's a second generation pilot study that focused on mobile persons such as truck drivers, fishermen and military staff. That study confirmed once more the very low prevalence rate in these particular groups. However, while the prevalence rate of HIV was only 0.5 percent, the rate of STIs was very high among this group of people. One of the recommendations made in this study was that communication and prevention policies should focus on increasing the general awareness of STIs, taking into account their manifestation and on their direct links to HIV/AIDS.

Now to talk about the most **vulnerable groups**: As Peter Piot said, today an efficient response to HIV/AIDS has to be a global one. And one of the main groups we have to integrate into our strategies is **homosexuals**. But how do we do it?

In this context, we are encountering tensions between the plain logic of public health policy and the tone reflected in public opinion and general social attitudes. While we cannot take the risk of excluding one group because of political or moral convictions, we can also not ignore societal concerns. When we started to work with young homosexual men, we noticed an emerging militant discourse. The big challenge is to come up with a way to work effectively with that group while avoiding the anger of religious people and society at large. And we have to strike a balance among the interests of the religious and scientific communities as well as the general public without calling into question the work done in over 18 years. This is a problem we still face. We now work with homosexuals in a discrete way. But we still need to define strategies that are clear and more systematic.

**Drug consumers** are another vulnerable group. Drug abuse is not a huge problem in Senegal. But while it does exist, it is an open door to the virus. We also need to take into account the hard drugs that are being consumed. This is a new phenomenon, though its significance is not yet very high.

Another vulnerable group is the population living in **conflict areas**. Senegal is a democracy. It is a country with a stable political system. But we also have a conflict area called Casamance, which has been in a state of conflict for over 20 years. Casamance is one of the areas with the highest HIV/AIDS prevalence rates, and it's important to come up with strategies for those living in such conflict areas.

**Prisoners** and **sex workers** constitute another vulnerable group. At one point, we discussed making condoms readily available in prisons. The reaction we got was that this was a problem because it would amount to an official endorsement of homosexuality in prisons. So it was not easy to talk publicly about making condoms available in prisons.

We also need a national strategy for **orphans** and **vulnerable children**. A workshop is being held in Dakar to define a national strategy plan that would take into account the problems faced by orphans and vulnerable children. Having in place a national strategy for those already living with HIV is very important too. What type of community services for people living with HIV could be feasible? When we talk about nutritional supplies, nutritional reinforcements, revenue-generating activities, or scholarships for orphans, what do we need to consider? Clearly, we need a well-defined national strategy for this.

Another problem we face is the **feminization** of the epidemic. While we see the same causes producing the same effects in both men and women, we still have low prevalence rates among women. However, we can see a worrying trend toward the feminization of the epidemic. A study I did in collaboration with UNEFEM clearly demonstrated that the estimated number of infected women in Senegal had increased by a factor of 4 over a period of 14 years, while for men that factor didn't even reach 2. So we really need to introduce a **gender dimension** to our national fight against AIDS.

**Cross-border activities** also need to be addressed. Can Senegal possibly stay an island of success and low prevalence while its neighbors are seeing rising prevalence rates?

A problem we have in our low-prevalence country is that most community organizations and NGOs don't engage in **care activities**. They are more specialized in prevention and communication. But concerning care activities specifically, there's a big gap. We'll need more and more NGOs specializing in care because we are moving to the decentralization and scaling-up of treatments, and the existing public health system won't be able to face this demand. So this is why it is important for NGOs and community associations to get involved in that process. It is also why we need a better **partnership between NGOs and the medical community**. Currently, there is some reluctance on both sides, and we should begin to create a basis for partnership.

Dr. Ndoye already talked about **stigma and discrimination**. But we also need a legal framework to address all those questions specifically, even if existing legal provisions in Senegal already protect people with HIV. On that note, we should not legislate when we have a legal device that takes into account the different problems related to law violations.

What then could be the role of the private sector? We often encounter **problems of ownership**. Most public sectors, with the notable exception of the health sector, have problems taking up their responsibility because they don't feel they have any ownership.

There are **coordination problems** among partners and with their interventions. Who has to coordinate? How best to maintain a **financial overview**? What's the amount of money entering the country? How is it used and distributed? Which actors are at the receiving end? Can we think of a common basket of resources for all partners involved? We also need an **operational monitoring and evaluation** system because we can certainly implement a nice scheme, but then we need to test it in reality and see how we can collect data in order to inform all systems. So let's take up this challenge together. Thank you.

### *Questions to Dr. Ibra Ndoye and Mme. Katy Cisse Wone, Senegal*

#### *Q. From one of the afternoon panelists*

I would like to know about the two phases. What are the added advantages, for example that you have seen by moving from phase one to phase two? Because I know that in most African countries this has been the trend. And secondly, the other part I would like to raise is what are the major challenges that you have faced to coordinate these resources?

#### *A. Dr. Ibra Ndoye*

I have some comments about the government initiative towards people living with HIV in the country. As I said in my presentation, we have two phases. In the first one, we had no treatment. In that period, people with HIV live in the society with some stigma and discrimination. But we have better results with stigma and discrimination when people living with HIV have access to treatment. Since this period, people living with HIV are real partners of national AIDS programs. They are involved as actors and they have created networks, not only at the national level but now also at a decentralized level, they have created regional networks. An important moment was last December; we organized the international conference of homecare. This conference has created a diminution of stigma and discrimination because we had a lot of television debates. And we are going to develop strategies to lower stigma and discrimination. But I think that stigma and discrimination are

one of the consequences of ignorance. I think it's a challenge for most African countries. The disease becomes chronic, and people infected continue their activities in the workforce where stigma and discrimination are prevalent, and where we need a public campaign to eliminate them. The studies we have done show the same **trends in urban and rural areas**.

***Q. SECO (DFE), Bern***

I have a question – can you give a comparison with what has been said about Brazil? Do you have data on the results, like infection rates, prevented deaths, survival rates? What do you think the realized economies have been? Did you do any cost-benefit analyses? And in the national strategy, were there links to an eventual poverty reduction strategy?

**A.** Unlike Brazil, we haven't such precise studies, but it would be good to find out. Regarding deaths, we are now able to prevent 70 to 80 percent of deaths we had before through access to treatment.

***Q. WIPO***

The delegates spoke about a lack of commitment by the private sector, and I have not understood well in what aspect there was no commitment by the private sector.

**A.** The intervention of the private sector began in 1994, but we only have about 10 companies of the 100 we would like. The Ministry of Labor has started a campaign to raise consciousness at the syndicate and employers' level. For example, Nestlé started such a campaign last week for its employees.

***Q. NGO, Geneva***

My question is concerning the Senegalese Government. What are their contributions and how is it all coordinated?

**A.** From the national committee, which is coordinated by the Ministry of Health, the advantages are the ownership and responses to other sectors. It's not easy at the beginning because each sector thinks its responsibility has been usurped. The program manager has to be very diplomatic and have a good sense of collaboration with the Ministry of Health. It's essential to have a close relationship between the Ministry of Health and National AIDS Council in order to avoid conflicts. It's important at the national level to have good coordination of all the funds (Global Fund, World Bank and the other bilateral funds) with the government, to avoid overlapping of intervention and financing. All donors have to work together in planning and implementing programs. Half of the AIDS budget comes from the poverty reduction program through the Ministry of Finance.

***Q. Franciscans International, Geneva***

I participated last year in France in a seminar organized by religious leaders concerning AIDS treatment. When religion involves itself in AIDS treatment, the infected patients often seem to focus on metaphysical questions, preferring to place their confidence in faith and refusing treatment. I'd like to know if you have that problem in Senegal of people refusing the treatment for religious reasons. My second question is about sub-regional action. I think that Senegal is a very attractive country and that lots of people go there. So when you focus your actions on the national level and neighboring countries, couldn't we have perverse effects?

**A.** Religious groups have a partnership with the doctors now. For example, we have religious NGOs who help us by providing doctors. With respect to sub-regional actions, migration is a big problem. We are currently working with our neighbors in Mali, Mauritania, and Guinea in

collaboration with UNAIDS to have access to antiretroviral treatments. With the initiative "Health for Peace" between Senegal and its neighbors, we work with UNAIDS to have efficient actions in terms of prevention and treatment between countries of the sub-region.

***Q. University of Geneva***

In the presentation, you have focused on the involvement of civil society, focusing more on national NGOs and national civil society. The question is: can you explain more and give more details about the participation of international NGOs, how they can contribute and if they are considered in these responses?

**A.** There is no discrimination between foreign and national NGOs. Some foreign NGOs came to me saying that as their country was financing the fund, they wanted to benefit from it. I don't think we can give priority to that kind of demand. We give priority to NGOs intervening directly in the country. For example, we have the International Alliance against AIDS in London with an antenna in Dakar that we work with. Anyway, we are receptive to those that add value.

***Q. University of Bern, Consultant to the African Union***

My question is a complement to the one about discrimination, but more about people living in Senegal affected by HIV. How have they been treated by society in Senegal as people and how are they integrated in the work force? How do people make them feel? Are there specific government initiatives to make those people members of society as they were before contracting HIV? Second question: given the acceptance of sexuality as a business as you mentioned already, what influence does it have on HIV because it has to do with sexual transmission? Are there records on the growth trend of rural and urban infected HIV patients?

**A.** We are against discrimination and stigmatisation for people living with HIV. Since the beginning of the epidemic we adopted a law to avoid discrimination and stigmatisation. We have a system to follow up sexworkers. Fifty percent of them are not Senegalese, and 12 percent of sexworkers are sero-positive. We maintain these people in our country and care for them as Senegalese.

**Floor discussion Comments**

***Ethiopian Mission to the United Nations***

I'd like to learn more of the Brazilian experience, particularly on the strong participation of civil society in all decision making; the participation of civil society as a very decisive partner has also worked effectively in Ethiopia. As it is now, our main challenge is the country's extreme poverty and population of 60 million people.

***UNAIDS***

We are looking for case studies that demonstrate that treatment can help enhance prevention. Is Brazil able to demonstrate that by scaling up the treatment, by having universal access, that incidence dropped? And if you are able to demonstrate that, have you looked at the detailed mechanism, have you analyzed it in detail, what really was contributing to this?

***International Federation of Social Workers.***

Two areas of interest. The first: is there enough use made by the media, films or television for possible prevention of stigmatization of sick people? Because I think this is a very powerful tool, especially in Brazil, where the novelas and soap operas have great influence. I know this is not so important in the countries where the majority lives in a rural area, but this is important

for urban areas. Second idea: in Senegal, where the great majority are Muslim, what about polygamy? On the one hand, it's been said it is better to have polygamy because sex remains in the family, so the men don't go outside and go to brothels. But on the other hand, instead of infecting one wife, you can infect four.

***A participant***

I would like to underline the importance of awareness. I think in most of the developing countries, especially in the remote areas, we understand that people have never heard of HIV and how to take care of it, so this is an important issue which needs special attention in the developing countries. And the other thing I'd like to refer to is the Doha Declaration, and specifically access to medicine and protection of medicine in the developing countries at special rates. I think this can be done through regional efforts like those I mentioned before, for example negotiation with pharmaceutical producing companies. Those countries belonging to a regional organization, for example the African Union, could really establish a very good deal with companies, and benefit to get medicine as well as condoms at special prices.

***Mme Katy Cisse Woné (Senegal)***

I'd like to add something about polygamy. I conducted a study two years ago with HIV/AIDS patients in hospital. The study covered a period of ten years. And the results show clearly that most of the males infected were males from monogamist couples, and that among polygamists, we had a very low prevalence. The problem is that women's organizations in Senegal don't want to hear that kind of information. They encouraged me to refrain from publishing the results, since they felt it would encourage the mullahs to advocate polygamy. This was a real dilemma for us. But clearly the study showed that the risk was higher in monogamist couples.

***A participant***

The question of supplementing patients with proper nutrition is a major challenge. These drugs are really strong, and you need to have proper food in order to support these drugs in your body. I'd like to hear the experience of Brazil about the subject.

***Ms. Meskerem Grunitzky-Bekele – Resumé on Brazil and Senegal***

What I can draw from this morning's session, from the experiences of Brazil and Senegal, what we have seen, what we have learned, is that the following are very important: leadership at the highest level, early response to the HIV epidemic, a balance between prevention and treatment from the beginning, and also the involvement of civil society.

Another thing we learned is the need for the structure of a national body to respond and to coordinate. The Ministries of Health are very involved. Brazil continues to implement in that way, and Senegal is experiencing working at high levels in order to achieve a multisectoral response. This is the comparative advantage of this new structure.

The two said that there are more actors, more funds, and more initiatives, which bring opportunities, but at the same time a lot of challenges. And Senegal especially has mentioned the problems of coordination of different actions, but also the challenge of decentralization, involvement of the community, and raising funds at the community level. Also, the problem of cross-border issues and the human capacity to respond to the epidemic, especially in the health sector for Senegal.

We have also seen that the two countries have been involved in supporting research on the impact of access to antiretrovirals, but also on the resistance of drugs. Brazil has experience in

the production of generic drugs at the country level and in conducting studies which have looked at the impact of all these interventions: cost-effectiveness of prevention and also of care. So we have learned a lot, which we hope will be complemented by the experiences of Uganda and Thailand.

## **Dr. Somyot Kittimunkong – Thailand**

### ***Country Profile***

I would like to begin with some background information on HIV/AIDS in Thailand. The number of people infected by HIV grew to about 1 million since the epidemic first appeared in 1984. The number of people who are still living with HIV/AIDS is around 600,000. The first cases we saw were among homosexuals. Then we detected infections among drug users and prostitutes, followed by infections in males with multiple partners as well as men who had sex with prostitutes. After that, the infection spread to pregnant women and children, and now the problem will increasingly affect our youth and mobile populations, if we do nothing.

So I would like to show a number of AIDS cases that were all reported in the last 20 years. The risks of infections in these groups are linked to sexual transmission. Luckily, we have seen fewer cases in the past ten years. What we tried to do in the past was not just to give condoms but also to provide education, strengthen our STI services, and other things. Condom usage doesn't yet reach 100 percent, but since we began promoting the use of condoms, we've seen fewer cases of STIs. In contrast, we saw an increase in the number of HIV/AIDS cases.

After we put in place the sero-prevalence system for direct and indirect sex workers, we saw that the trend was positive and that we had fewer problems with new infections. We also put in place the sero-prevalence system for pregnant women, male conscripts, and blood supplies, which showed similar results. In addition, we introduced a program to prevent mother-to-child transmissions. Taken together, this shows that we have seen some success in reducing the number of new pediatric AIDS cases.

I would like to give some details on the evolution of the AIDS committee and share our strategy with you.

### ***Organization***

We saw the first case of HIV/AIDS in 1984. In 1987, we launched the prevention and control project under the auspices of the Department of Communicable Disease Control. After that, we realized that we had more problems, so in 1989 we adjusted our strategy and established the Executive Committee on AIDS Prevention and Control, presided over by the permanent secretary of the Minister of Public Health. In 1990, we changed this to the Advisory Committee on AIDS Prevention and Control project, which was presided over directly by the Minister of Public Health.

Early on, we knew that the problem of HIV/AIDS was not just a health problem, which is why we sought cooperation with other sectors. In 1991, we established a subcommittee on cooperation with other public and private sectors and set up the AIDS Division of the Department of Communicable Disease Control. After the 1991 "coup d'Etat," a new government took over, which showed a very strong commitment to the fight against HIV/AIDS. By 1992, we also had an HIV/AIDS Prevention and Control Committee at the

district and provincial levels, presided over by the governor. So at the time, we began to set up a comprehensive system at the national, provincial and local level. This is the organization we have today. It includes vertical and horizontal coordination at all levels.

I would like to talk about the former Minister Mechai Viravaidya and former Prime Minister Anand Panyarachun.

Both of them showed a very strong commitment to the fight against HIV/AIDS. Dr. Mechai Viravaidya said: "I convinced him (Former Prime Minister Anand Panyarachun) that *he* should chair the National AIDS Prevention and Control Committee, not the Minister of Public Health. Ministers are not the most powerful, they cannot demand the full cooperation of others, and they cannot order a change in the budget - but the Prime Minister can." So – if you ask why Thailand was successful, high up on the list would be political commitment.

When we changed the structure of the national AIDS committee at a time when the Prime Minister chaired the national AIDS committee, we integrated the national AIDS plan into the country's five-year development plan, and we also received more money devoted to the fight against HIV/AIDS. If we take into consideration external assistance and funding, the Royal Thai Government spent a lot of money on HIV/AIDS programs after 1991. Before 1992, only the Ministry of Public Health got the budget for HIV/AIDS programs, whereas from 1992 on, every ministry involved also got money.

### ***Community Initiatives***

The money is also used to support NGO community initiatives. This has the effect that the ministry and NGOs have a shared responsibility and accountability in the fight against HIV/AIDS. The budget for a number of NGOs increased every year since the Thai government began supporting them in 1992 until 2004. But in 1997, when we were facing problems related to the economic crisis in Asia, we were forced to cut the budget. But in the last four years, the amount of money allocated by the government to NGOs has been around 70 million baht.

I want to talk about the home and community-based care initiatives we have implemented in pilot projects in the northern provinces of Thailand including Chiang Mai, Lamphun, Chiang Rai and Payao.

Many of these initiatives were launched by NGOs at the beginning of the HIV/AIDS epidemic in our country. While we have seen some success in our work with NGOs, the groups of people living with HIV/AIDS in our upper Northern provinces have been increasing in numbers annually since 1993. In the Northern parts of Thailand, we get lots of HIV/AIDS cases.

### ***Communications Campaigns***

After 1991, we had lots of mass media campaigns. This is why we had so much success. Radio and TV stations are controlled by the government, so when the government decides to broadcast information on HIV/AIDS, it's easy. I think we have a pretty good infrastructure in place. Even if we have black and white TV, many people are able to receive information on HIV/AIDS. Here's another factor – when we want to promote the use of condoms, it helps that Thailand has already had family planning campaigns for a long time, even before we had problems with HIV/AIDS. Because of this, Thai society is more open to the promotion and use of condoms.

When we think about the elements of a comprehensive strategy for fighting HIV/AIDS, the most important one may be information. We need information on the disease, we need to know when it starts, how to stop it from spreading, how to treat and cure people. We need to use this type of information as a basis for our strategies.

The second element of a successful strategy deals with the way we think. We have changed our thinking and have undergone a paradigm shift. HIV/AIDS is not only a problem of health. It has other components that are of a social or economic nature, which we have to address.

The third element I would like to talk about is the vision we have for successful partnerships. We know that the disease has multiple faces and problems, so we have to work with others in finding solutions to reduce the negative effects of HIV/AIDS. This is why we have the National AIDS Committee, the Subcommittee, and AIDS Committee at both the provincial and district levels. We want to let other groups and other sectors participate in the decision-making process and let them devise their own strategies to effectively fight AIDS in their local communities.

So to overcome the main obstacles and formulate effective strategies, one of the most difficult aspects is to persuade different sectors and people to share a common vision and decide when to launch HIV/AIDS campaigns. Second, we have to solve economic and social problems and the problems associated with stigma and discrimination. This prompted one individual in Thailand to point out that people were not dying of HIV/AIDS but of social isolation. If the people in the community do not accept them, how could they live in that community? Third, it is critical to have efficient organization, such as when we want cooperation from other sectors. Sometimes it's quite difficult to ask them to join us. And finally, we need to prioritize the allocation of resources. During the economic crisis in 1997, we had to cut back our budgets. However, in the past three years we were able to bring them back up.

### ***Obstacles to Successful Implementation***

I think that one size cannot fit all because if we look at Thailand, we have very different geographical regions. In the southern parts of Thailand, for instance, we have Muslim communities, so sometimes it's difficult for us to promote the use of condoms. Nonetheless, we have several groups of young Muslim organizations that work with us to promote educational strategies.

When implementing our strategies, we try to be pragmatic in the selection of our target groups and intervention activities and to ensure their **affordability and sustainability**. What we tried to do last year was to promote the installation of condom vending machines in schools and universities. At the time, we received lots of criticism in the Thai media. Many people didn't agree with us, and we were forced to stop our project. Our opponents argued that if we put condom vending machines in schools and universities, it would only encourage our youth to have more sex. We were, however, able to provide this service to other groups, such as factory workers. I would just like to add that when we tried to promote condom vending machines, we made sure to keep the price for condoms low. For 5 baht you put in the machine, you get six packs containing two condoms each. So in your local currency, that's about one Swiss franc for six packs of two. Or in other words, for one Swiss franc you get twelve condoms. That's quite cheap.

Summing up, were we to explain the phases that Thailand went through in its fight against HIV/AIDS, I think we can divide them into three phases. The first one is the health program from 1984 to 1990. The second phase was our social program which ran from 1990 to 1996. And since 1997, we've increasingly been trying to engage civil society in our activities. Finally, I want to mention that we will be the host country for the 15<sup>th</sup> International AIDS Conference in Bangkok from July 11 until July 16, 2004. I'm sure quite a few people in this room will be attending. Right before the conference, we are also holding the AIDS Competence Knowledge Fair in Chiang Mai on July 8<sup>th</sup> and 9<sup>th</sup>. That will be a chance to exchange ideas and practical experiences drawn from recent responses to HIV/AIDS that were covered in the world or even local press.

### **Dr. Tangcharoensathien Viroj – Thailand**

I'd like to share some additional experiences from Thailand. This will be a brief presentation on the experience we've had with prevention and treatment of HIV/AIDS in order to identify the factors that determined success and failure.

#### **First of all, I'd like to highlight the legacies of our health system.**

For one, we very much rely on the capacity of our health system, which forms the backbone of every public health intervention. I'd like to draw your attention to the fact that our health services cover quite an extensive geographical area. We provide services at the sub-district, district and provincial levels. This kind of backbone is needed to successfully implement and integrate public health programs, including AIDS programs.

#### **The second legacy I'd like to point out is human resources.**

For over three decades now, it has been mandatory for all new graduate physicians, dentists, pharmacists and nurses to provide services to rural communities for at least three years. This experience forms the backbone of the system. We have 25 cohorts of competent epidemiologists, trained locally over a three year period by the Ministry of Public Health, and we have an additional 1,000 epidemiologists working for the Ministry of Public Health. So this backbone is the strength of our country. And finally, there has been very little international brain drain to the US and Europe. All of our well-trained experts came back to help their homeland. However, we do have a brain drain problem at home from the public to the private sector.

#### **The third legacy of our health system is health financing.**

We have adequate financing for the poor and have been targeting the poor for the last 25 years before introducing universal health coverage in 2001. We also have an extensive national health system that is funded by taxes and low-cost fixed payment rates – so called capitation.

#### **Lastly, I would like to point out our health policies and research capacity.**

We have gained quite a bit of local knowledge on how to institutionalize health system research and local capacity, that is, on integrating research results into policies and practices. Our success story included prior policy analysis, which led us to design the present universal coverage system based on a capitation contract model.

Next I'd like to highlight three factors which could contribute to the successful prevention of HIV/AIDS.

**First and foremost is political commitment.**

The only partnership that is genuinely effective is one that is based on inter-sectoral cooperation between government agencies and non-governmental organizations. We have funding available to support NGO activities plus adequate funding for urgently needed activities. We want to highlight the importance of social, financial and human resources. While we rely heavily on national resources, we are relatively free from donor-driven agendas and fragmentation.

**A second factor is policy decisions based on solid foundations of evidence.**

Every January, we conduct an annual census of the sex industry, we put out annual sero-sentinel surveillance surveys every June, every province has its own sero-sentinel surveillance site, and we conduct an annual survey on sexual behaviors, also every June. Over the last two weeks, I personally went to visit brothels, karaoke bars, and other establishments in four or five provinces. And I was able to take note that they use condoms and have safe sex. In some provinces, new risk groups are now being included in sero-sentinel and sex behavior surveys, such as students in vocational schools.

**The third key factor for success in prevention strategies is implementation capacity.**

I'd like to highlight the health system backbone as a legacy that's been in existence for over 30 years. We are continuously revising and adjusting our strategies, as more evidence becomes available.

Thai people are quite pragmatic. We have the right moderate approach. When we have money, we move ahead with our approach. When we don't have the money, we slow it down. For example, the local production of low-cost antiretroviral therapies prompted the government to adopt a system of universal access to ARTs, but prior to that we simply could not afford to do so, nor did we want to borrow any money to do so.

In the beginning, we started slowly, so as to gradually build up our capacities. I think a couple of months from now we will be able to introduce nucleic acid amplification testing, which is the most advanced blood safety technology in Europe and in America. We cannot afford to let time pass in making such new treatments available to patients.

We have experience in piloting large-scale implementation projects. For instance, we implemented 100 percent PMTCT coverage within two years and moved from focused targeting to comprehensive interventions – and as Somyot said, from health to non-health interventions. So we have the capacity to implement effective policies, such as promoting the use of condoms, even if this needs to occur gradually.

**However, we face three major challenges to our prevention strategies.**

A basic problem is that complacency resulting from signs of success could be a root cause of failure. The government cannot afford to get complacent about prevention now, even though the infection rates among high-risk groups have gone down. Despite our first successes, we have a couple of unfinished items on the agenda.

Slow progress has been made in advancing life skill development, providing IDU interventions, or combating discrimination practices in certain business sectors. A new challenge is posed by changing sex behaviors. Increasingly, we are seeing more casual sex and low rates of condom use among young adults and adolescents. This means the message about safe sex did not adequately reach everyone outside the commercial sex industry sectors, and we need to do more in this respect.

### *Treatments*

I will identify three of the key success factors in regard to treatment. At this point, it is difficult to say whether we are successful in our efforts to scale up antiretroviral therapies (ARTs) because we only started implementing them in the middle of last year. However, by last month we registered 35,000 ART enrollments in the Ministry of Public Health program and related government and private-sector schemes. In total, the social health insurance scheme and all pocket schemes could be something like 45,000 enrollments today. That's quite a rapid scale-up. We continue to work very closely with the World Bank Group and other groups to evaluate the costs and consequences of antiretroviral therapy. Our long-term goal is to be able to produce figures similar to those that Brazil presented this morning.

The first key factor for successful treatments is the health system backbone implementation capacity and a strong and extensive coverage of Voluntary Counseling and Testing (VCT), the quality routine laboratory and CD4, and viral load backups in hospitals. We integrate prevention, treatment and care into the same set of services. And over the last ten years, we've gained some experience from small-scale mono and dual therapies.

The second key success factor is financing antiretroviral therapies. We rely more on government budgets than on donor sources, which will ensure long-term financial sustainability, especially in the post-Global Fund era. Most importantly, we have affordable low-cost local production of generic ARTs and other OI-related drugs, and we produce adequate first line regimens of ARTs for our national program.

The last key success factor is the network of people living with AIDS. They've demonstrated a very significant role in facilitating rapid enrollment and providing other social supports to those enrolled.

However, we also need to concentrate on three unfinished agenda items.

Initial late recruitment of known people with opportunistic infections is one – more than 50 percent of those in enrolled in antiretroviral treatments have a CD4 count of less than 100. The question is how to accelerate early enrollment and improve the clinical outcome.

A second concern is the possibility of stagnation in our scaling-up efforts. After all known people with opportunistic infections have been recruited, we need to understand the demand for voluntary counseling and testing (VCT) among the general public and among high risk groups. We need to understand demand for antiretroviral therapy among those with known asymptomatic HIV and those who have a CD4 count of below 200, in order to stimulate demand for antiretrovirals (ART) and voluntary counseling and testing (VCT). I think I will put our backs against the wall for the scale up of ART by the middle of next year. We also need to understand demand characteristics and functions in order to stimulate demand for VCT and ART.

And finally, regarding the quality of VCTs. VCTs constitute an important component of a successful antiretroviral treatment program, but we are currently witnessing a drying up of our human resource pool. Faced with a rapid turnover in counselors and clinicians, we will need a long-term human resources plan.

I've identified three potential causes of implementation failure. These were constraints on both the supply and demand sides and on the financing of ARTs. On the supply side, these can take the form of brain drain when the economy catches up and private hospitals face an increasing demand, while the public sector continues to be the major hub for the distribution of ARTs. Regarding problems on the demand side, I'd like to highlight poor adherence on the part of patients, which can lead to clinical failure and costly second line patent drug regimens. Irresponsible behavior can potentially lead to the spread of resistant viral strains, so in addition we need quality counseling on safe and responsible sex. To add another point – the issue of providing equal access to ARTs for the poor and economic opportunities for those enrolled in ARTs programs needs further investigation.

And when talking about financing – there's uncertainty of how secure the availability of government financing is in the long run, especially with an increasing demand for expensive second and third line drugs.

Regarding the Global Fund – there is the uncertainty of a grant renewal in the second phase. The potential for an interruption in our program is a global concern, and we must not lose sight of fostering preventive interventions because ARTs take out a lion's share of our AIDS program budget.

Finally, in the context of increasing resources, what are the further challenges? We think that money is necessary, but it alone does not provide the answers to all questions and problems. Knowledge, a functioning health system, and implementation capacity matter! This is the strong message we wish to convey for further discussions.

Our policy goal must be to reverse the trend of an increasing number of new infections. We cannot afford to lose sight of more cost-effective prevention interventions, and we need to increase our efforts in providing ARTs. A rapid scale-up of ARTs that is not carefully planned is doomed to failure. This would be an unaffordable failure.

We need to strike a balance between short-term and long-term investments in our health system and our human resources. While the Global Fund provides financial support, we believe that our development partners, especially the WHO and UNAIDS, have a moral responsibility to strengthen health systems and implementation capacity, both for prevention and treatments. Otherwise, by 2010 or 2015, we'll look back at missed opportunities. And I don't think we can afford to lose those opportunities.

A successful program would need to see the uninterrupted renewal of grants in a second phase under the auspices of the Global Fund. And there is an urgent need for financial projections into the future beyond Global Fund support, especially in settings with limited resources, but also where adequate resources are currently provided for. Due to the price of antiretroviral therapies, we have seen decreases in Brazil, Thailand and many other parts of the world. But when you have clinical failure related to the first line regimens, you have to come up with second and third line patent drugs, and this is difficult because there are no generic substitutes at this point in time.

## Questions

### ***Q. One participant***

What are the determining factors to make the price of condoms so affordable?

#### ***A. Grangeiro***

Two main factors have been fundamental to the reduction in the price of condoms:

- 1) Similar to the case of Thailand, the affordable price of raw material, and
- 2) The state together with the private sector is managing the whole process, not only the production, but also the distribution to schools, universities and workplaces.

### ***Q. Michel Kazatchkine, France***

One of the strong points you made, Viroj is about going slowly but solidly somehow. Yet I wonder how do you prioritize, based on that philosophy, access to treatment? You told us that obviously one of your priorities was people with known OIs. But the demand for antiretroviral treatments is still probably far beyond the current 25,000 that you have under treatment. So how do you prioritize, and is there a consensus of civil society and of the public health sector on how patients are prioritized for treatment?

#### ***A.***

In the initial phase, we recorded the non OIs with the CD4<sup>2</sup> count. And there is no quota because the government budget estimated that some 65,000 had not reached the target yet. So there is no paradigm. But the problem is the missed opportunity because the convention we have cited here was for a couple of days, for a post test and for a CD4 count. Then in provinces where they cannot do all processes within a day. They can enrol into ART, IE pre-test and post-test in the morning and CD4 count test in the afternoon. We invite the patients to come the next day and ask them to decide on ART enrolment. Then we need to understand the demand function, the demand characteristic for those who are HIV-positive but asymptomatic and who didn't know their status.

### ***Q. ILO***

First question: as we heard this morning with Alexandro, they have an initiative with 14 other countries to also spread their approach in Latin America and I would like to know from you how are you going to do this kind of approach in your area, in Asia? Second question: following a symposium we have just had in Africa concerning HIV/AIDS and the response of the public sector, what place is there for programs in the public sector, meaning in the line ministries, especially education and agriculture, and is there any evidence that we can maybe replicate in other countries?

#### ***A.***

Our collaboration with other countries varies. We have collaboration with Cambodia, Myanmar, Mongolia, China and part of India in some areas. We have collaboration with India,

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<sup>2</sup> A type of T cell involved in protecting against viral, fungal, and protozoal infections. These cells normally orchestrate the immune response, signaling other cells in the immune system to perform their special functions. Also known as T helper cells. 2. HIV's preferred targets are cells that have a docking molecule called "cluster designation 4" (CD4) on their surfaces. Cells with this molecule are known as CD4-positive (or CD4+ ) cells

Thailand, Brazil and South Africa on AIDS generic production, which is a very clear output of the Dubai Conference. They still have an ongoing dialogue. We have collaboration with China on production at low cost in the future. I will also respond on access to condoms. The cost of the common distribution for one condom is one baht. 40 baht = \$1 so condoms are very low cost because we have now self-sustained local production. Condoms are one of the medical devices under strict FDA control. We test them very carefully. And we include condom distribution through common outlets reaching the high risk group that is just coming to sex. Otherwise, for the family purposes, the common outlet is still used for 50-70 percent and one third are sold in the private market place.

***Another comment (Viroj)***

One initiative from one of our NGOs is the Thailand Business Coalition on AIDS. They work with the Ministry of Labor and some of the factories. They have developed correct conduct and they give certification with factories complying with the correct conduct. There is no stigma and discrimination in that place and the policy adopted in the factory deals with the testing for HIV. We have just signed it a few weeks ago.

***Another comment (Somyot)***

I also want to add something about the entire therapy of PM Cities Plus that we extend not just for infections from mother-to-child, but we also have the asymptomatic check-up for the father. We give the drug; we have the CD4 count testing for the mother, but also if the mother has a low CD4 count they can make use of the ART free of charge. And if they have the problem with CD4, they can enter therapy.

***Comment from Brad Herbert, Global AIDS Fund***

There are several issues which are related to the decision points. There is one as to what do you do in the resource constrained environment. There is another issue that comes up as to who should actually approve the go decision for phase two. As you know from the previous Global Fund Board meeting, that decision was made and it should be up to the secretariat to make the go decision. For the no-go decision it would be the Board of Directors based on recommendations coming from the secretariat and Taxonomy of Requests by Patients (TORP)<sup>3</sup>. I think that was supported by the Board and by the secretariat because it seems to be the most efficient way, and it also ensures not only efficiency but timeliness by ensuring that there would be continuous financing between phase one and phase two. And if there were not going to be continuous financing, that decision would be taken in an earlier part of the current agreement. There should be an interesting Board discussion now about whether or not they reverse that decision.

***Answer***

Our country is weak in implementing the program. This is the debt problem we are facing. A weak health system cannot deliver and cannot demonstrate good performance in Global Fund implementation. And it's the moral responsibility of our country partners like WHO and UNAIDS to support and to improve our performance. I'd like to have a further discussion in the general discussion.

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<sup>3</sup> The Taxonomy of Requests by Patients (TORP) is a refined system for characterizing patient requests and physician responses in office practice

## *Presentation by Dr. David Kihumuro Apuuli – Uganda*

### *Country Profile*

I'd like to state that I'm just going to give you a snapshot of the Uganda story, as it is an interesting and a sad one at the same time. Elizabeth will fill in some of the gaps in areas such as voluntary counselling and testing (VCT), prevention of transmission from mother to child, (PMTCT), antiretroviral treatments (ARTs) and other areas. So I will limit myself to explaining what happened in Uganda and what we think were some of the things that made a difference, even in an environment with limited resources.

I find it very interesting to talk about resources during a time in which things happened when there were very few resources available. I'll start with an explanation of what happened among the general population.

Right from 1995, when the prevalence in the general population was about 18 to 19 percent, you can see a decreasing trend, down to 6.2 percent and about 5 percent in 2003. In fact, the prevalence rate in rural communities is lower than the prevalence rate among the urban population. That shows you that the country is not a uniform entity. I can assure you that in certain areas of Uganda, the prevalence rates were higher than 30 percent. But what you need to note is that, based on our second-generation surveillance studies, the trend for all of our 20 sites is that prevalence rates are dropping. And indeed, we also have evidence that in fact the number of cases has been going down as well. This year we are conducting a national sero-sentinel survey in order to validate our findings.

But behind those graphs there is a human face. I know I told you I was not going to bother you with figures, but let me tell you one thing. Our success is sad because we have lost so many people. We estimate that we have lost about 1 million people. And I can assure you that there are very few people in Uganda who have not lost a sister, a brother or a cousin. For us, HIV is real.

Even now, our figures indicate that in 2003 about 70,000 Ugandans died of AIDS and that there were about 75,000 new infections in the country and that about 73,000 contracted AIDS through blood transmissions. We found ourselves in a situation that put us at the epicenter of HIV/AIDS in the world, and we have the poorest people who require care. We estimate that 100,000 to 150,000 people require ARV treatments. We had a meeting last week and we estimate that in order to provide ARV treatments for all these people, we'll have to provide testing for 10 million Ugandans. You can imagine what this would involve. And the population of Uganda is currently 25 million people.

We also estimate that the annual loss in total GDP stands at 0.8 percent. Now, Uganda's annual growth rate is at 5.7 percent. For the last 17 years, we would have been growing by an estimated 7 or 8 percent a year, were it not for the AIDS epidemic. So we have conducted a number of impact studies on various sectors, but I won't bother you now with all these details. I will give you my business card and point you to our website, which will give you all this information.

The first purported case in Uganda was in a small fishing village on the shores of Lake Victoria. There was no structural response until the new government came into power in 1986. I remember sitting in a meeting with our Minister of Health, and he stood up and announced

that we had AIDS in Uganda. And the Ministers of Health from all over Africa were very concerned about the implications. Breaking the silence helped our country assess the situation and prevent a catastrophe.

### ***First AIDS Control Program***

In 1986, the first AIDS control program was set up by the Minister of Health. He began to announce useful messages by “beating the drum” because in Africa, when there is a problem, when there is a warning, people beat the drum, and when you hear the drum in Africa you take action. In 1987, we heard spontaneous responses from various people, but not by the government. And the same thing happened in 1989 when one person came back from Sweden and said, “I have AIDS.” And people simply couldn't believe it.

So the Minister broke the silence, and we had various people come forward. First we established the AIDS Information Center and then the Uganda AIDS Commission chaired by our President.

### ***Multisectoral Approach***

The multisectoral approach was born and bred in Uganda, I can assure you. In 1995, we conducted the first vaccine trials on the African continent. We then developed the National Operation Plan before decentralizing our efforts. So all responsibility was brought down to the districts. And then two things happened. In the year 2000, the government formally agreed to integrate HIV/AIDS into its poverty eradication action plan, called the Poverty Eradication Strategy. In 2001, we saw the birth of the Partnership Forum. Among other things, what happened then was the initiation of AIDS competence training with the support of UNAIDS, the implementation of PMTCT guidelines, and the coordination of VCTs.

But let me elaborate on all these things. It's true that Uganda is a relative success story in Sub-Saharan Africa. I want to state, because we are supposed to state, that what made this story a success was the following.

One important thing that has come up in all previous presentations is the political commitment at the highest level. Let me tell you, the President didn't waste any time. He walked on foot from village to village and addressed the locals. In 1987/88, he told them we have a problem, we have a crisis, and if we don't do anything, something catastrophic will happen.

By 1992, the government had launched the multisectoral approach, a holistic response that did not leave the health sector as the only one to mobilize and manage financial and human resources.

So right from the beginning, having realized that this went beyond the capacity of the health sector, the President himself founded a committee which he convened every month. He asked everyone to share the information they had on what was happening and so, in turn, was able to give them guidance. That committee was the eventual predecessor of what is now known as the Uganda AIDS Commission, the first commission to be set up anywhere in the world.

Now as for the AIDS Program – a systematic program was first launched by the Ministry of Health in September 1996, and then other ministries followed suit, such as the Ministry of Defense. The Minister of Health did a lot in terms of establishing a surveillance system, making sure to capture important information, starting new programs, and being able to

provide treatment for potential infections. And indeed, he laid the foundations for donors such as the World Bank and others to come forward and provide assistance.

So now I think I will move away from the Uganda AIDS Commission and talk briefly about the National Strategic Planning Process. It is very important that every country have an integrated HIV/AIDS plan. We started as early as 1993 to develop a national operation plan. It provided a strategic framework that guides all our partners, big and small.

### ***The Three Ones***

Just at the end of last year, we conducted a mid-term review, and we have now revised the plan. As I'll be explaining later, this plan is what must guide the other three principal instruments we have on hand: one national coordinating authority, one national action plan and one national monitoring and evaluation framework. Next week we will be finalizing a memorandum of commitment. Every donor, bank, fund, US AIDS, the U.S. Government will sign a memorandum of commitment to follow the set of principles underlying these instruments, so that everybody is in the picture and we only have one vision. And when being scaled up, the plan will emphasize these principles as guidelines for the reduction of prevalence rates and strengthening of international capacity.

I want to shed more light on the Uganda AIDS Commission because I think it is an example of best practice.

I come from the health sector, I was the Director General of Uganda's AIDS Service, and now I am the Head of the Commission. The Commission was established by law, and there is nobody who can just come and remove it. If you want to change that law, you have to take it to our Parliament. Secondly, there's a board appointed by the President and myself, the Chief Executive, and we work on the board for a period of time. The people who work in the Commission are not civil servants. They come and work there on contract and are employees of the Commission. But its main functions should really be seen in terms of policy guidance and formulation in order to mainstream the HIV/AIDS policies across different sectors, such as the education sector, the agriculture sector, at ministerial level, and so forth.

Somebody must be able to facilitate this process, which is why we are required to help in planning and monitoring programs. By monitoring program implementation and the use of resources, coordinating and spearheading a sustained response, and promoting HIV/AIDS research, we facilitate the partnership efforts of everyone involved.

### ***Coordination***

By the end of the 1990s, the multisectoral approach had shown some considerable successes, but not everything was all right. We saw the creation of AIDS control programs within different Ministries, but there were gaps that convinced us of the need for a multisectoral approach that would develop into a cross-sectoral partnership. One problem was that there were simply too many actors.

In Uganda, there are more than 1,000 NGOs involved in the fight against HIV/AIDS. You know the people who are bringing money into the country, but then you need to be able to involve all these people. And when we looked at all this, we noticed that the right hand didn't know what the left hand was doing. At the same time, the NGOs were saying, "But you are not coordinating with us." In addition, the UN insisted on taking over the leadership through the

theme group. And yet, the theme group was not at all representative. So, together with UNAIDS and all other partners, it was decided that we had to do something about this.

### ***Antiretroviral (ARV) Treatments***

What are we going to do about this? How are we going to be able to coordinate everybody involved? I can assure you, and Elizabeth will tell you, that out of the 60,000 people receiving ARV treatments in Sub-Saharan Africa last year, about one third were in Uganda. And a very interesting thing: ARV treatments were not free of charge, as they were in other countries. People paid for them out of their own pockets. As the prices went down, their numbers went up. We just reviewed the number of people with ARVs last week. There are about 23,000. Free ARVs really just started to come about in the last two months.

Up until then, people were paying themselves. Why? Because we had in place a workable model based on a private-public partnership. The essential drugs were imported by a public institution, and people came and paid for them. That organization charged a small markup, which allowed it to import more drugs – and more people. People traveled to Uganda from Kenya, Rwanda, Tanzania, and as far as Zambia to come for ARV treatments. It was a very innovative system run by a public-private partnership. And today, many people are assisting in the expansion of this program.

Having said this, another aspect of our work that required partnerships was getting greater involvement from people living with AIDS. These are voiceless people, so we needed a stage, a forum in which they had a voice. They had to come up and join the high table rather than remain in the kitchen and be told what to eat.

So I will describe for you a structure that devolved from our country's multisectoral approach, a structure in which all these people with their small voices can speak up with loud voices, such as through the President Bush Initiative. Of course, there was the question of decentralization once the implementation process was extended to the districts. We had support to give to the communities and districts, so that they were able to develop competencies and capacities. But how do you reach all districts in such a big country? How can all of their voices be heard?

### ***Funding***

It's true that we had very little money when prevalence rates started to come down. Today, we have various resources to fall back on. We are part of the President Bush Initiative, the Global Fund, and many other programs funded by the American Government. The total amount of funding for HIV/AIDS under the Bush initiative for Uganda is 94 million USD. This is for twelve months. One thing that I would like to say to the Global Fund, the World Bank and everybody else. If you decide to go to a country to help, respect the existing institutions that were put in place for coordination, and above all respect their principles. We thought it was necessary to establish a sub-committee to oversee and coordinate all programs as part of a single partnership, so as to make sure that the right hand knew what the left hand was doing, and that they respected and saw each other.

These are all major challenges, but let's think about the different systems which could help in our coordination efforts.

As you could see, prevalence rates were going down. But we now have a new generation of young people who were not there when the drum was beaten, who didn't see as much death.

You first see a rate of 6.2 then 6.5 percent, and then a leveling off. So clearly, this requires us to look at the whole picture in a different way and to develop partnerships that address all relevant issues.

One of these challenges is how to take care of all the orphans. In Uganda, we have more than 2 million orphans... 2 million out of a population of 25 million! Everyone of us here has an orphan living with them. In my home, we have orphans. Twenty-five percent of all homes in Uganda have at least two orphans on top of the family they have. And fertility rates in Uganda are very high. They're now at about 6.9 percent. So with even more people, an increasing number of families are driven into poverty.

A goal of the aforementioned partnerships is to minimize these negative effects by engaging all stakeholders, using resources within the framework of one national strategy, and maximizing the potential for harmonization and joint accountability in order to reduce transaction costs and increase the effectiveness of our programs. In a next step, we need to provide local communities with the resources they need and increase efforts in order to scale up the national response, while providing mechanisms that allow all stakeholders to participate in a coordinated manner.

### ***Uganda AIDS Commission***

There is the Uganda AIDS Commission. There's a Board appointed by the President. It's the Board created by law that makes policy decisions on HIV/AIDS and passes them on to the President and the Parliament for approval. This group here is composed of both elected and appointed representatives. You can see there are about eighteen in total. You must know that national NGOs, international NGOs, even members of Parliament have been elected by the Parliament to come and sit on this commission.

Faith-based organizations, people living with AIDS, media representatives, the youth, the United Nations, research institutions, and local governments all participate. In the center of all this are major strategic players, such as the Ministry of Health, the Ministry of Finance, the Ministry of Gender, UNAIDS, and the Uganda AIDS Commission. This Committee convenes the last Friday of every month and discusses the HIV/AIDS agenda. Everybody comes and is accountable to this organization. And at the end of every year, there is a partnership forum. This is when everybody meets in the conference center and participates in a joint review of the year, of progress made in different areas, and of programs that are being undertaken. Everybody in the partnership has the right to say, "I think something is going wrong." After all, we are accountable to the people of the country. This is what the partnership committee is all about.

### ***Partnership Forum***

Yes, there is financial support coming in from different sources – there is money from the Global Fund, there is money from US AIDS, there is money from the government. But in making the partnership structure work and in order for constituents to achieve their stated goals so as to be able to speak with one common voice, further costs are involved.

This is why we established the so-called partnership fund, which is supported by countries such as the UK, Iceland, and Norway, all of whom brought in a lot of money. Things such as the national strategic framework would have never been possible without those funds. Basically, these funds assist the commission and other partners in performing their functions.

I have talked about the partnership forum. This partnership forum is very important because this is where everybody comes to listen to what everyone else is doing. It is a forum to discuss issues you are not satisfied with. An institutional structure that focuses on the epidemic and involves everybody needs to be put in place to address these challenges in order for other countries to move ahead. For us, who are at a relatively low level of prevalence, we have to focus our efforts on bringing down the curve on that graph. As a first step, we have to think about adjustments to the management of our multisectoral response.

I want to stop here and ask Elizabeth to talk about the many issues I have not touched upon, including major challenges we face. PMCTC, she will tell you, is only at 5 percent despite the fact that Uganda is a low-prevalence country. Last year, only 5 percent of all mothers accepted to join the program. Why? You need to look at several factors. ARV treatments, how do we scale them up? And how do we scale up our efforts in a country that has so many of the world's poorest people, not just ten or twenty thousand but hundreds of thousands of people.

### **Presentation by Dr. Elizabeth Madraa, Uganda**

The Director General of the Uganda AIDS Commission has just outlined how Uganda has moved ahead since 1996 to put in place a comprehensive framework that has allowed us to reach the levels we have today. But I don't just want to leave it at that. I don't think everything is rosy. We face significant challenges, mostly related to HIV/AIDS programs in the country and necessary human resource capacities.

#### ***Human Resource Capacity***

We are witnessing quite a large brain drain right now – not only to Northern Europe or North America, but even within Africa itself, particularly to countries with an influx of other resources.

The brain drain is mainly from the public sector to NGOs, which is where the money is. And that's really very dangerous because when I see some of the recruitment ads for positions within the Ministry of Health, most of the doctors who apply for these jobs are those already working in district hospitals. So you wonder what is happening. We are draining resources away from the public sector, as people follow the money trail. How do we address that issue?

We have had a recruitment ban, which has just been lifted, and this is the result of the structures I just explained. Now we are trying to fill positions which are still vacant, but there is not enough money to recruit. What is going to happen with all these programs which we are trying to scale up, such as the VCT, the ART program and the prevention of mother-to-child HIV transmission? We need more resource capacity, especially counselors, but that is not an established position. We also need lab technologies and pharmacies. Medical doctors are very few in number as well. So we have to work out some mechanism by which we can achieve all this with existing levels of human resource capacity.

#### ***Coordination***

We've got problems with procurement activities and logistics. A lot of issues are manifesting themselves now as we scale up VCT and ARVs. What can we do when we don't have efficient supply chains and logistics, from procurement to drug distribution. Add to that the issues of quality assurance and coordination. Coordination is not a matter that can be dealt with at the national level. I think it should be the focus of the donors within the country. But how can

they coordinate themselves? We often evaluate our own programs, but I'd like to pose the following question: how do we evaluate the donors themselves within the country? Everybody would surely have an incentive to look at what their own money was used for and to see what its impact has been.

While we need to look at this, we should also think about coordination efforts at the national level in order to harmonize the use of those resources that have come into the country from donations. If we fail to do this, what we are going to see is unproductive competition. While money should be used to make a positive contribution, it should not lead to competition. But how can we make sure it doesn't? This has been a very big challenge to us.

The coordination mechanism at the country level has been well described by Dr. Apuuli. After all, this is what the partnership forum is all about. How to use all available resources efficiently and effectively is the big challenge we face in our HIV/AIDS programs. Of course, we first need to be able to map the resources we have available, regardless of who donated them. This way these resources can be shared equally with civil society organizations, the public sector, and with whoever else is involved in the HIV/AIDS program. Otherwise, we would have a situation in which someone says, "Don't touch! This is mine because I've been given the money to treat a number of patients for a certain part of the year." Or a patient might come and say, "That's mine, don't touch!" On this note, we have now started to target patients living in the country's cities.

### *Sustainability*

We have money available for field missions in the country, which we received from the Global Fund, from the World Bank Project, and others. But we don't know where the next funds will come from. So what about sustainability? Well, we can't really say how sustainable our efforts will be, especially now that we are starting with ARV treatments. The costs of drugs are likely to drop, which is fine, but since the country does not own the necessary resources, but is dependent on external resources, we don't know for how long funds are going to continue to flow in.

Our policy in Uganda is free access to ARV treatments – that is, free ARVs for those who are eligible to get such treatment. We have also made provisions for those who don't wish to go to the public sector to line up. At the end of the day, however, somebody has to pay somehow. So what we are trying to do is to work out a health insurance mechanism that will allow the private sector to continue to provide treatments at a cost, as it already does, but that will also make available some form of subsidies for patients.

With support from the World Bank, we started to procure drugs worth 3 million USD for the public sector, which have been distributed to about 26 centers, including our regional hospitals and non-profit NGO facilities. And we are currently awaiting another 1.7 million USD. Under the Global Fund, we got 7.6 million USD in a first round; of that, 7.4 is to be used for procuring drugs. And I believe the rest of this money will be for managing the program itself. In a third round of the Global Fund, the grant agreement, which has not yet been signed, should be worth about 7.4 million USD. This, too, would be for the procurement of ARV drugs. But since April, I've been waiting to see our procurement plan ready to be finalized and sent to the Global Fund. Two months on, we were asked to clarify certain issues. We have still not sent the procurement plan, and I don't know when it will be ready. But I'm happy that the Global

Fund is here. We need to sort out certain things. What will the procurement system look like? When will it be established? Will you act to make commodities quickly available to those countries that need them?

It's about dealing with the bureaucracy, the bureaucracy involved in procurement. This applies both to the Bank and perhaps to the Global Fund. And yet here we are – we want to see the drugs out there as quickly as possible, see the pills reach the people. How do we avoid coming to a grinding halt as we are in the process of rolling out to the ARV program?

Maybe, Mr. Chairman, that also needs to be addressed when we are discussing issues with the Global Fund and WHO. This applies to the VCT we are rolling out, but the same issue is relevant to the prevention of mother-to-child HIV transmission. While it is necessary to provide effective care services, prevention will still remain our key concern. And in that case, we also need to go back and revise some of our strategies such as IEC. We need to assess how we can best mobilize society and improve programs that are already in place.

The problem is not money. The challenge is to make sure we have the necessary capacity and an understanding of working in partnership. Above all, the country needs to tackle the problems we face in a concerted way within the same structure.

### **Panel discussion**

#### ***Dr. Michel Kazatchkine, Chairperson***

What we will be discussing here are basically lessons learned from what we've heard today from the four countries making presentations and basic challenges that are ahead of us.

Let me first very briefly introduce what I've heard from the four countries in terms of factors of success. I heard that the response to HIV/AIDS has been **comprehensive** and **multisectoral**. Obviously there are multiple components to the success with mobilization of civil society, with implementation of treatment, political commitment and multiple components. But all of them, all four spoke about a comprehensive and multisectoral approach.

The second thing I heard was **leadership** – political leadership. We've heard of Presidential and Prime Ministerial commitments. We've heard also about the countries' ownership of the fight against AIDS, and I also heard, maybe to a lesser degree in Senegal but I know the process is on, about decentralization. We heard that right from the beginning. We saw it in with the federal organization, mapped to where the epidemic is. We've heard about decentralization from Uganda and we've heard about this strong backbone of public health organization in Thailand from Viroj.

Then I also heard about the fact that all of these countries **intervened early**. And this to me is something that is key: early intervention. And we must draw those lessons for the countries that are still early in the epidemic. And here I have a question for the four panelists which is: what in fact triggered this very early response? Is it a political decision, is it an individual or is it civil society? Certainly it wasn't the pressure of the disease at that time, but why did you all start so early to respond? I consider my country in 1985 -- it was already pressured from the disease that was visible and the mobilization of civil society. It was true all over Europe and in the US, but what finally was the trigger for action in your countries?

Then, finally I heard about a **balanced approach to prevention and treatment** in all four of the interventions. And I also heard with regard to treatment about free ARVs. Almost all of you somehow told us about either free ARVs or strongly affordable ARVs, which we know is the number one factor for attraction and then for success.

Now I have a question for the panelists. What do we mean by success? We said today the four countries were “successful”. But we are far from that goal even if all of these four countries are considered, so I personally think that success is **decreasing the prevalence**, which is something we can measure by having started implementing ARVs and looking ahead to scaling up. The very success to me is in these components that I was mentioning as sources of success, that is: leadership, comprehensive approaches, early intervention, a balanced approach to prevention and treatment.

***Mr. Jean-Louis Lamboray, UNAIDS***

I have a question for all panelists. I know that progress started even before major international help came into your countries. That was in the early nineties. Now I'm concerned as a person in the UN, what do I tell countries in need of help? What are the four common points emerging from your experience that you would wish me as your ambassador to convey to another country, so that there wouldn't be four countries in the panel but five, ten and twenty.

***Dr. David Kihumuro Apuuli, Uganda***

I'm going to say what triggered the response in Uganda. I think that some of you may know what I'm going to say or may have read a book called "*The Open Secret about Uganda*". In 1986, Uganda emerged from a civil war and the present government took over control. And a lot of the combatants, as they came to start off the country, didn't know that they were carrying HIV/AIDS. They had to send about 60 army officers to Cuba for training. And these officials who had signed up, who had been fighting in the bush with the President for about five years, he valued them and he was trying to turn the army into a conventional army. So they went to Cuba, and you know the police in Cuba tested everyone. When they tested these people they found that out of 60, 18 were positive. So in the non-aligned summit, President Castro met our President and said, “I think you have a problem of AIDS in your country.” Our President realized he was sitting in Cuba and didn't know what was happening in the population at home. So he realized that there was a lack of structure in the country and if they didn't do anything, this nation he had fought so hard to get on a proper footing would just perish.

***Dr. Elizabeth Madraa***

What triggered the early intervention in Uganda was just described, but also everybody went through the epidemic like a war where everybody should be involved. And of course, you can only do that when you have a government system that supports the intervention itself. The leadership came in 1986. If you look at the time we diagnosed the first two cases in 1982, up to 1986, how many years do we have? About four years, and that was a lot of time lost. And this was not only the case for Uganda. It was also the case for Kenya and Tanzania. In Eastern Africa, no government mentioned intervention on HIV/AIDS. The soldiers were living within the community, within the population. And of course if the children were infected, they picked up the infection from the community. So even when the political commitment is there, community mobilization for action and social mobilization is still key. If you want anything to succeed, involve the community, support the community, mobilize the community. And then you can see things moving. Of course the implementation should be decentralized to lower levels of implementation. Some countries decentralized only nominally. They keep the

money, they keep the power and they don't decentralize anything. Nobody can act without money. Do 100 percent decentralization, build capacity, send the money there, support the people in the districts. To reach every corner you need to reach out, and then of course, you need also to support recommendations made by civil society, especially people living with HIV/AIDS. For us, it changed the picture in Uganda. And then, of course people need to know their sero status. That's why we're promoting counselling and testing. And we say let the counselling be supported as a service that should be mandatory. But testing can be optional or voluntary. We are changing it the other way around and finally the mature sexual approach still is the right approach.

***Dr. Ibra Ndoye, Senegal***

To answer the question of the triggering factor, in Senegal we discovered the first AIDS case in 1986. In the beginning, the media talked a lot about the HIV/AIDS epidemic. Within a research collaboration framework, between Dakar, Boston, Tours and Limoges Universities, we started research about a prostitute population we were managing at the time. We could demonstrate that among the prostitutes there was a virus which wasn't HIV 1 and which had identical characteristics. This is why it's often said that the Dakar school contributed to the discovery of the so called HIV 2 virus. When we got the results, I was invited to Geneva, and they showed me the ravages that this epidemic was already causing in some African countries such as the ex-Zaire. We took the documents of our study and met with the Head of State and told him that some African countries were still denying the virus existed, but we thought that Senegal could not deny the existence because it was a real epidemic and we needed to react. This is how we started in Senegal, with the involvement of the Head of State, and things started to move.

***Dr. Alexandro Grangeiro, Brazil***

I would like to underline three aspects related to the early response in Brazil:

- First, we managed to understand that the epidemic had an accelerated rate of growth and that it was hitting specific categories of the population and causing their stigmatization;
- Second, during the creation and implementation of our AIDS program, we were also completing the reform of our health system, which responds to the principles of universality, equity and social participation. This gave us the opportunity to adopt such principles in the AIDS program.
- Third, the response process took place in a historical moment for Brazil: when after the strain of the dictatorship, we were building up the basis for a new democracy with powerful participation from the social sector and civil society.

Also, in relation to the concept of universality of access to treatment I would like to point out that the secret lies in the spirit of the Doha Declaration. It is true that the principles set in Doha are not easy to implement and that developing countries need human and material resources, specifically cooperation to reform our intellectual property legislation, technology to improve production of ARVs, and more initiatives similar to the Canadian one to produce pharmaceuticals at prices affordable for developing countries.

In relation to the question posed by Mr. Lamboray, I would like to mention three issues:

- 1) The role of a government should be to drive health as well as trade and financial policies on the basis of a human rights approach, with a specific focus to the most marginalized.

- 2) Horizontal cooperation among developing countries. The country experiences analyzed today show how much we have in common and the extent to which we can exchange precious information.
- 3) A North-South transfer of technology concerning the production of drugs as well as several other health-related aspects (monitoring and assistance)

***Dr. Tangcharoensathien Viroj, Thailand***

Just to respond to some of the previous questions, I'd like to propose four pragmatic approaches for a country with very low prevalence. The country might start first with the introduction of sero-sentinels in a small site, and introduce a sex behavior survey and then the second step is to accept if it is a problem. If it's not a problem, declare it as a potential HIV/AIDS problem. Politically it's a problem to accept in public. And the third step is to introduce pragmatic selective interventions, because the resources are limited. The most cost-effective intervention is promotion of condoms in the risk groups because if you know the number of sero-positives, the most efficient, cost-effective way is to interrupt infections from A to B. The fourth step can be a more comprehensive approach to poverty and AIDS through a more organized national AIDS committee. So the real message is hit hard, hit early, no matter if it is a problem or a potential problem.

***Dr. Michel Kazatchkine, France***

Let's now move to the challenges that we have heard. I heard many of course, as did you, and we will not have time to cover all of them. I'd like us to start with three issues. One deals with coordination, both at the national and international level. Then I'd like us to talk about the best use and channelling of available funds. Then I'd like to talk about access to health care. And then if we have time we should speak about human resources.

We have heard particularly from our African colleagues that in the country there should be a national program. Then there will be the donors' programs, each with their own constraints in regard to what should be implemented, the nature of the program, and even sometimes the nature of the drugs to be used for treatment and constraints in monitoring and evaluation. And then we have a number of UN agencies involved. Each of them has a role that I think is unclear on the ground and often overlapping with the role of the bilaterals. We've heard about the enormous waste of time and effort that this overlapping has cost. Dr. Ndoye spoke about it very clearly. We talked about the Three Ones. We talked about the potential conflict of a national program, a CCM and the Three Ones. How is the CCM disturbing this?

***Dr. David Kihumuro Apuuli, Uganda***

I spend a lot of my time talking about the importance of coordination. We must recognize that people work on HIV/AIDS for different reasons. Some are philanthropical, some have genuine human concerns and some work for strictly financial gain. That was a problem at the beginning in 2001. So we had to evolve different systems and we did. We had a lot of help. We asked UNAIDS and WHO to send us assistance. It took about five months to reach consensus on what should be done. The UN, the bilaterals, before coming to the meetings, they meet first and come with one voice. By the time they come, they have agreed on the agenda on a particular issue and only one of them comes to represent their entire constituency. But the biggest challenge is of course coordination at the lower level. Since we have a structure that has been agreed on by consensus, it's to have a sub-committee of that structure that will bring all these programs together and make sure they are complementary with others.

***Dr. Ibra Ndoye, Senegal***

We need to see the problem in terms of AIDS coordination. In the UN declaration in 2001 it was agreed that there was a unique action framework and I think that in the Three Ones, the action framework permits all partners to intervene in all countries. Countries also were asked to raise the leadership to the presidential or prime ministerial levels in Africa in order to ensure an appropriate response by all sectors. Most African countries have respected those rules. The national councils, at least the national council of Senegal, not only take into account the national partners but also the bilaterals, the UN system, civil society and the private sector. At the beginning it was not easy because when we started that job in Senegal, the Health Ministry also wanted leadership for malaria and tuberculosis, which created a competition between the Health Ministry and the National AIDS Council, which is an obvious coordination problem. This morning I thought to myself that if we need to respect the Three Ones, wouldn't it be good to have a number 1 Country Coordinating Mechanism (CCM) for malaria and tuberculosis at the Health Ministry level and also to have a number 2 CCM but integrating the HIV/AIDS action framework. So I ask the question because somewhere we need to find a solution which could help the execution of World Bank funded projects and so on. I ask this question because before these funds did not exist. I think that the coordination was led at the Health Ministry level. We should not waste time today because of a lack of coordination.

***Dr. Michel Kazatchkine, France***

Thank you. I'll ask Brad Herbert to comment later on the CCM issues and Gottfried to comment, on behalf of the UN agencies, on what you think would be the effective role of the various agencies and what it should be at the national and international level. Viroj or Alexandro, do you have a comment, on international coordination?

***Dr. Alexandro Grangeiro, Brazil***

On the issue of cooperation I would like to remind everyone of the important role played by international organizations. The spread of HIV/AIDS should represent for them a new opportunity of doing business and cooperating with the affected countries. We should forget the idea that some know the truth and others don't; we should abandon certain patterns of cultural and intellectual domination. Developing countries know pretty well how to face the epidemics and need international organizations to prioritize and complement governmental action.

I would also like to make a few comments on the action of the Global Fund. Brazil is not implementing projects with the Fund, although we are working with World Bank financing. From day one, we decided that the National AIDS program would have total responsibility for these projects, in order to maintain an integrated response to the epidemics. Within the National Program we have created "Committees" which ensure a broad-based participation in the decision-making process. Any time we create a parallel structure, as happens with the CCM, we create parallel powers, conflicts and duplications which undermine the effectiveness of this response.

***Dr. Tangcharoensathien Viroj, Thailand***

I am very pessimistic about coordination and I don't think there's an easy answer. I've worked closely with Laos and Cambodia and have seen lots of problems there in terms of bilateral donors. Last year, economists published a very good paper. In the list of bilateral donors mentioned were a US and a Japanese one. I'm not criticizing that, but I refer to The Economist publication which mentions the best as a Scandinavian bilateral in terms of capacity building. They were focused on infrastructure, buying equipment, purchasing vehicles, equipment, extra

machines, hospital beds, etc. Some agencies chose three northern provinces, others two central provinces and NGOs another two southern provinces; they were fragmented. I'm very pessimistic about effective coordination, and I call for more attention amongst multilateral and bilateral donors to be better behaved.

***Dr. Michel Kazatchkine, France***

Let me turn to another issue now. That of getting the best use of available funds. We've heard from Elizabeth that funds are at last coming in. There is an obvious issue of what the technocrats call absorptive capacity. We've heard that, at the country level, funding HIV/AIDS may compete with other health issues when so much money is channelled for one particular disease. How will the countries deal with other health priorities and the Millennium Goals? We've heard that the money that comes in constrains the way the programs have to be implemented. This is of course somewhat exaggerated, but for the sake of discussion, I've heard on the one hand "let's go slowly but on solid ground." We saw Brazil relying primarily on its national resources primarily and so did Thailand. We saw Senegal, which also said "let's increase our access to treatment and care but not more than we can do at the time." On the other hand, I've heard Uganda say, "let's take the challenge of accessing Global Funds, plus the World Bank, plus others with very large amounts of money" and try to manage them effectively. These are key challenges for the next two to three years.

I'd like you to comment on whether one should go slow and, as a result, leave out a number of people because even if I understand well, Brazil actually provides treatment to 25 percent of the estimated infected people in the country, Thailand may be less than 10 percent and Senegal as well. One can say "we do provide treatment to a higher proportion of people who actually know their status" but one could argue that "let's use much more funding to be much more aggressive." As you from Uganda said, "let's identify more cases and treat more people if we really want to pick up the challenge."

***Dr. David Kihumuro Apuuli, Uganda***

One thing we must realize is that people with AIDS are human beings and I think we must recognize that studies on cost-effectiveness or treatment are no longer questionable when you provide people with ARVs. We must also realize that in terms of the family as a unit, as a household and often in poverty, needing to care for the elderly and the sick are dimensions that challenge the human being in terms of equity. It's true that the question of the sustainability of these programs arises when we consider the provision of free ARVs. This is a big question because we don't know how long it is possible and what will come after the Global Fund. So I think we need to move fast. I've told you the number of people we have lost: over one million people, and for us this was the epicentre of the epidemic. There was a summit of Heads of State from Central and Southern Africa which discussed what to do when funds dry up. In a communiqué they said governments should start to put aside some funding for a rainy day. Can we start thinking about this future and start planning for the rainy day when funds from the Global Fund and the rest won't be able to sustain us. We hope at that time, the prices will have gone down sufficiently for us to be able to continue.

***Dr. Elizabeth Madraa, Uganda***

I'd like to draw your attention to the diversity at this table. If you compare Brazil and Thailand with others, there are quite a few differences. I'd like to look at the epidemic and then see how it hits each of the countries differently. When I talk about best use of resources, I am looking at addressing the issues of HIV/AIDS and what the countries have done – we do review the poverty reduction plan, we are addressing the issues of HIV/AIDS as a disease, we are looking

at the issue of infrastructure and how the system works within the program. We are again looking at the issue of poverty within the households hit by this epidemic, which must be addressed. You do not address the issue of the social sectors or support to the household in isolation. You go further; you look at the issue of community support. Dr. Apuuli talked about orphans. Those are all issues brought by HIV/AIDS with other diseases with multiple social problems. Sometimes money comes in regardless of the national plans which are there, supporting the same issue, like the MAP. Then another program would say that they were sending money to civil society organizations. With the same channel, you send money and coordinate without knowing who has supported what and what is the gap that needs to be filled, so the resources are going there. Right now we are going to have huge support for action in this program. Why do you want to look at abstinence in isolation, looking only at prevention. And addressing the target issue. This is again an issue where we don't want to look at how this money is being used and the issue of women getting more infected. So, Mister Chairman, we must look at the best use of resources, and we need to strategically plan where we want to spend resources.

***Dr. Ibra Ndoye, Senegal***

Well, on the resource issue, we weren't greedy at the beginning because when we saw the invitation to get funding from the Global Fund, we saw there was a lot of money, but our strategic plan over the six years was \$100 million and we had \$30 million from the State taken from the poverty reduction program plus what the State annually gives in funds, \$30 million with the MAP project, and the other partners gave \$15 million. There was \$25 million remaining. We could have said we would submit a request for \$25 million to the Global Fund, but we thought that we could ask for only \$11-13 million and try to see how we could be efficient because when the epidemic began, there was not enough to permit other countries to benefit from these funds.

There's a problem of procedure with some partners. Sometimes countries are accused of delaying and creating a problem in credit absorption, but we are often asked to prepare an annual work plan and provide the funds to execute it. There are administrative board meetings and we lose time, and money doesn't come on time to the countries. So I'd like us to think about the availability problem and being able to quickly mobilize funds at the country level. This is in terms of available resources. I think it would be good that the resources be available in the countries. In Senegal, if we had to wait for the Global Fund, and even at the beginning of the MAP, we would have treatment ruptures. This is why we think that for sustainability purposes, countries involve themselves. What if the Global Fund dries up or international support doesn't come, the programs should continue anyway. But I think that programs start with the countries allocating budget resources for ARVs. In a country funded only by the Global Fund, and where the World Bank doesn't allocate anything to an ARV budget, there will be long-term problems.

***Dr. Alexandro Grangeiro, Brazil***

Today we are in a situation very different from 10 years ago; today no one may question the importance of free and universal access to treatment. However, we struggle when we have to prioritize the scarce resources available. Here I would like to put on the table a provocative question: Is it really an issue of funding or are existing institutional conditions in affected countries inadequate to meet the current needs? This is the problem. I believe that these conditions are completely inadequate for an effective absorption of the funds available. All the main actors, including civil society, international organizations, and national and local institutions should focus on the need to improve countries' effectiveness in purchase and procurement; and to increase transparency and reduce corruption.

***Dr. Tangcharoensathien Viroj, Thailand***

There have been two international experiments in the past three or four years. Countries with a GNI less than \$1,000 usually spend less than \$10 per capita on health, opting to purchase one childhood vaccine at \$5 per dose. If the Global Fund terminates in five years, the programs will not be sustainable. This kind of analysis prompts you to challenge Global Fund support. The only sustainable answer is low-cost, effective treatment. The country will have to choose and be responsible, not thinking about today but about five years from now or beyond. The price of drugs and antiretroviral treatments is key to sustainability.

***Dr. Michel Kazatchkine -- Comments***

I've heard a lot about the challenge of the access of people to health care but they do not know about their serological status. We heard about Viroj's concern as to what will happen once everyone with a known OI and an obvious need for treatment will have entered the system. There's another issue I would like to raise, that is the fact that all discussions are really focused on what we call the AIDS emergency. Of course it's an emergency to fight against a disease that we are turning into a chronic disease, and I think we are thinking very much in terms of interventions similar to those that we would have in an acute situation, rather than thinking about chronic disease. We heard about the cost of drugs. Also all the numbers you had to deal with in terms of what we call the first line treatments. When people will have to turn to second and third line possibilities, we'll have to have more sophisticated laboratories to monitor treatment. Costs will be even much higher.

Then I heard a lot about human resources. Either the money is in NGOs, as we heard from Uganda, or the public sector or private sector. We also heard about the need to go for alternative ways of delivering care, and we heard about community-based care, particularly in Northern Thailand. We have no time really to go into the details of monitoring and evaluation on what we should measure in terms of impact, short-term, long-term, incidence, prevalence, mobility, mortality or some of the much more social aspects of AIDS, since this is a comprehensive response that we are providing. I've heard about two issues that are more specific. One is the cross-border issue vs. the national and how do we deal with that in the future. Viroj briefly touched on this. There is positive action at the Thai-Myanmar border, but there are also lots of problems there. And also the issue of the plateau. We saw in Uganda this fantastic decrease from 18 percent to 6 percent prevalence and now we see the 6 percent prevalence plateau which is of course an extremely high prevalence. And what's the reason for the plateau and how do we deal with the plateau, after you've been able to have this great success in decreasing prevalence.

## Closing Remarks

### *Joseph Ingram*

Brad, can you and WHO make a few closing remarks on behalf of the agencies. Michel did ask a couple of specific questions which I hope you can address, especially WHO.

### *Brad Herbert, the Global Fund -- Comments*

Let me first address some other questions that came up concerning the Global Fund. Let me say categorically that the Global Fund fully supports the concepts of harmonization, coordination and the Three Ones. It would be impossible for the Global Fund to succeed if we were to ignore them. The Global Fund makes grants after two years initially. It takes about two years to put a new system in place nationally. It takes two years to develop a new harmonized system, a new reporting system. We cannot afford the time nor can we be servants of time, creating something new for a new organization. So as far as we are concerned, and I speak as Chief of Operations of the Global Fund, we fully support the Three Ones. I think there was some confusion in the early days about CCM. We just conducted 24 case studies in 24 countries of CCMs, and the issue about Three Ones being somehow incomparable with CCM. It's an issue that's basically going away in many countries. It still exists in some countries, and it still exists in Geneva. But it does not exist in all of the countries where we are doing business. So I think they are comparable, they need to be comparable, and we will certainly do everything to make it so.

On the use of money. I want the Global Fund to move away as quickly as possible from quarterly disbursement, to six-month disbursements or to annual disbursements. We need to apply lessons learned; we need to manage our risk. And that means if you are a good performance recipient, if you have ongoing programs with other partners, and are successful, then we will provide resources more easily. It's a direction we need to go towards in terms of managing risk. We cannot continue to have high transaction costs. We disburse money based on performance. I'm very pleased that we just conducted an analysis of the 25 grants that are celebrating their first year anniversary this month. Of the 25 grants, 48 percent have disbursed 91 percent of the money that they had requested, that was in the original work program. For 32 percent of the countries, they used about 58 percent of the money. And for the countries that we have concerns about, 20 percent of those have managed to spend only 27 percent. That is linked directly to the performance that they've achieved during the last 12 months.

About the questions I was asked to answer. It seems to me that the issue of capacity of human resources really was directed at me. When I look at the 20 percent of countries that have only achieved 27 percent, it really is an absorptive capacity issue. But then having just said that, let me change. I don't think it's just absorptive capacity. I think that it's more a question of distribution of capacity within countries. I think what we need to be doing is opening the markets. Yes there is an absolute role for the public sector. But we know that the Global Fund is additional money. That means additional work. And can we afford to spend five or ten years building the public sector up to absorb this additional money? Or do we find ways to unleash the talent that exists in those countries, unleash the capacity of our technical partners, UNAIDS, WHO and others who have tried but are not yet funded to do this. This is a major issue that I think we need to confront. How is the necessary technical assistance that can be generated to help unleash the talent in countries going to be financed? This is an issue that the Global Fund board and the boards of the respective agencies here need to be addressing. When we unleash the talent, we need to unleash the talent of women in these countries. If you look at

this very good book that the World Bank has put out about education, there's a graph in it which shows that twice more victims of HIV/AIDS are women. And I have heard almost no discussion today about the role of women in helping address this disease. **So when we think about moving towards distribution of capacity, let's think about the role of women. African women can fully participate in the solution of AIDS.**

On behalf of the Global Fund I'd like to thank the World Bank and UNAIDS for inviting us. It's been a great opportunity for us to hear about what's happening in these countries. In my country we have an expression: "Nothing shouts louder than success." I think all four countries have demonstrated degrees of success. But it also leaves me with a very uneasy feeling, because another 100 countries out there are not as successful. So the challenges are still there. And I'd like to question how do we replicate this? How do we take what you've learned and you've achieved and replicate it in the other countries?

*Dr. Gottfried Hirnschall, WHO*

I'd like to address the challenge of coordination first and then make a few additional observations. WHO is fully supporting the concept of the Three Ones. We don't just want to talk about it, we would like to work with you at the country level to come out with country-specific solutions to be really in line on this issue. Obviously we need to move beyond the conceptual phase and really move into an operational response to the Three Ones concept. And that's the real challenge that has come out of the discussion today.

UNAIDS has committed itself to work specifically to document in some countries how the Three Ones concept can be addressed. And I think that's the right way to really see how different countries may be responding in different ways. I don't think there is one solution that fits all countries. I really think we have to be creative and inventive; we have to think beyond the usual ways of working with each other and to document very carefully what works and what doesn't work.

On the WHO side, the question has come up of WHO's role vis-à-vis the UN agencies and vis-à-vis the UNAIDS secretariat. I'm trying to address a little what we see as WHO's role. Our mandate is expertise and things working within the health sector. That doesn't mean that we only and exclusively work with the health sector. Of course we fully support a multisectoral response to HIV/AIDS with other UN agencies that have expertise, such as the ILO, sitting across the table, and the World Bank. With UNAIDS at the country level, WHO would like to work fully in the framework of the UN team groups. And we know very much that in some countries this works better than in others. But we would like to strengthen the concept of the UN team groups to work, move even beyond the traditional UN team groups. We are actually part of UNAIDS, but the secretariat of UNAIDS has strengthened UNAIDS country coordination in many countries to more fully fulfil its role. WHO is recruiting additional technical staff to more fully realize the role in technical areas vis-à-vis the health sector. We are currently recruiting 40 additional staff in our country offices to have full technical competence and capacity in those country offices in the area of HIV/AIDS.

The second issue that has been addressed was absorptive capacity and the use of committed resources. Our colleague from Uganda, Dr. Elizabeth Madraa has addressed this very well. It's probably not the amount of money which is coming in, it's the way it is coming in and the way it's planned and how it's going to be used. And that again, relates to the first point that has been made. How can we coordinate better and anticipate the need for resources better.

A lot of discussion has focused on the need to strengthen the health system. In countries where the health systems are strong, obviously the response is stronger. In countries where the health systems are weaker, obviously it's more difficult to build up a comprehensive response. The argument I'd like to make is we need to have resources available to strengthen the systems while we build up the response. We cannot say let's build first a system and then respond. I think these things have to go hand in hand and the key is to have the resources available, both financial and human resources and the technical capacity to really build the ship while we are sailing and therefore funding is essential.

There has been some discussion on prevention, treatment, care, and isn't this too ambitious – the Three by Five? We in WHO don't think it is too ambitious. It's maybe not ambitious enough. Still, 50 percent of the people will live without treatment who should actually get it. And some years ago, nobody would have dared to say well, if there is treatment available, why not offer it to people who live in the South in poorer countries? It was actually something one couldn't say. Now we can say it. We can say within a certain time limit, a certain number of people should receive treatment, and some time later everybody should have it. And let's find the resources to actually provide that treatment. We must be careful not to say just provide treatment and don't do anything else. Clearly, we advocate a well-balanced, comprehensive response that needs to address the needs in the area of prevention, treatment, and care.

The strange thing that we now see is, when we say 50 percent of people should have treatment, those people who didn't want to talk about treatment before now turn around and say they do. This is a very difficult issue because it raises the question of equity. Who should get it first and who later? But I think the argument that we have been trying to make is let's get started and let's get started with full support and as quickly and as much as we can.

A couple of things also related to the response that WHO would like to offer to countries. There's generally a lack of managerial capacity, and if we as the UN agencies only focus on technical inputs, we know we don't provide a good enough service. So there is a clear lesson for us to improve our managerial capacity to provide you better assistance in those areas where they are lacking. Important issues are: procurement and supply chain management, pricing, and price negotiations. Bringing the prices down for sustainability has come up on several occasions. We are working on building up the AIDS drug and medicine services system, the AMDS, which should be a service used by countries to get information on best prices, on procurement issues, but also on improving your supply chain management system. The system has just been built up. It's been using as a model the global drug facility built for TB, and we hope to have it available for all of you within a relatively short time.

Another issue that has come up is how we can approve learning across countries. I assure you that we see a strong input of WHO in facilitating the process. And again, it shouldn't just be the typical have and have-not exchanges. Like Brazil, countries in Africa have made great progress. Countries in Asia should be able to have access to that knowledge, and see if what they have learned can be applied well in other countries. I think that as part of our Three by Five strategy we need to see how we can foster that exchange.

I know we are running short of time. I'll stop here. As a closing comment I'd like to say that it's been very encouraging for me to see that the issues that have been identified in the discussions are basically grouped within the five pillars that we have put in our Three by Five strategies. That there is this commitment and advocacy at the highest level; policy and normative guidance from the WHO side; and again a mutual learning process that needs to happen. I also include operational research and partnerships. Nobody can do it alone. We

need to work together in doing it, and from the WHO side this includes the provision of technical and managerial assistance to countries and programs.

### ***Joseph Ingram – Closing Remarks***

First of all, let me thank all of the country representatives for their interventions, and the other speakers and panelists as well. This has been a day rich in information and experience. Let me add something to what I said in my opening remarks. I talked about the Copenhagen Consensus and the fact that eight economists who got together in May, including three Nobel Prize winners, agreed that among the ten major global issues to be resolved, the one which would provide the most benefit in terms of cost, is dealing with HIV/AIDS. What I think we've learned today is that it's easier said than done. How you get benefits is not so easy. We can all acknowledge the benefits in relation to costs for economic and social development, never mind the morality. But what we have learned today is that doing so requires both strategic thinking and vision and a commitment to both preventive measures and treatment.

Finally, let me say something about coordination, which has been much evoked today. We strongly believe that country ownership is absolutely essential in the fight against HIV/AIDS. And the fact that we are supporting governments through the implementation of poverty reduction strategy programs (PRSPs) is testimony to that belief. We think that the PRSP is an important instrument, though as I've said before, is still very much a project in the making; it's a very dynamic process and the newer generations of PRSPs are much better than the first generations, and they will continue to improve. But the process that is put in place is what is critically important in that it puts government in the driver's seat. How the government chooses to use that process will determine how successful it is in coordinating not only the various ministries within government and the NGO community within each country, but also how successful you are in getting the donors to coordinate amongst themselves. I think David and Elizabeth, in describing the tough position that the government of Uganda and its President are taking vis-à-vis the donors, are basically telling Mr. Bush thank you very much for the \$150 million but we will do this on our terms. We want to be the owners of this program; we don't want you to come in with a preset program and tell us, "OK, here are \$150 million, here is the way we want you to implement the program!" So I think and I hope that the PRSP process is seen as an instrument by which governments can more effectively coordinate all aid, as well as policy implementation, both at the country level and at the international or global level.

One last thing – in the last few months I have had visits from people at WHO and from ILO, and the discussions in both cases were focused on how they (WHO and ILO) can become more involved in the PRSP process at the country level. How can we as a donor community use that process more usefully to insure that our assistance is spent effectively? How can we in effect meet the priorities of the government? These are serious efforts on the part of WHO and ILO, and it is an encouraging sign. The fact that at the same time WHO is strengthening its presence with the recruitment of 40 new people at the country level to work on HIV/AIDS is also an encouraging sign, especially if those staff are deployed in countries where effective policy and donor coordination are taking place through the use of institutionally managed instruments such as the PRSP.

