Universal Access: Right Here, Right Now

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Executive Summary

In July 2010, the XVIII International AIDS Conference (AIDS 2010) took place in Vienna, with the theme “Rights Here, Right Now.” The conference came on the back of both the G8 and G20 Summits, and immediately before the African Union Summit where commitments made to the Abuja Declaration would be reviewed. In September and October 2010, the global community will meet once again for the Millennium Development Goal Review Summit and the Global Fund Replenishment Meeting. This has made the year 2010 a critical year to re-examine commitments made to reaching essential international development goals such as universal access to the prevention, care and treatment of HIV/AIDS for 2010 and the Millennium Development Goals for 2015.

UNIVERSAL ACCESS IN 2010

In 2006, governments made a vital commitment at the United Nations to scale up international efforts for the AIDS response, uniting under the Political Declaration on HIV/AIDS for the provision of universal access to HIV treatment, prevention, care and support to all those in need by 2010. Since 2002, there has been increased investment in HIV and AIDS, more than has been applied to any other human health challenge in history. In March 2010, the International AIDS Society (IAS) launched the global Universal Access Now Campaign to ensure that world leaders are held accountable to the universal access pledge, to ensure that HIV/AIDS remains part of the global health agenda, and furthermore, that the universal access pledge is taken forward beyond 2010.

This report looks to some of the principal coverage of universal access at the XVIII International AIDS Conference, including the data, publications and presentations which served to underscore where the international community now stands in reaching the vital commitment made in 2006. It aims to highlight key outcomes on universal access at the conference including Taking Stock of where we are now in terms of international access to treatment and prevention and the outcomes of the major international interventions. The report also underscores Current Challenges to Reaching Universal Access, including the current economic climate and donor retreat.

Finally, the report presents the routes for The Way Forward: Scaling up to Reach Universal Access advocated at the conference, notably the need to replenish the Global Fund and new opportunities for effective prevention. These include the Treatment as Prevention paradigm which featured prominently at the conference, advances in prevention technologies such as microbicides and additional support for male circumcision, combination prevention and the UNAIDS launch of the Treatment 2.0 Campaign. This report demonstrates that while great progress has been made, the international community must continue to make universal access a priority.
DOING MORE WITH LESS, OR DOING MORE WITH MORE?
The international AIDS response is at a critical juncture. Not only is a stronger effort needed to reach universal access targets by 2015, but revised treatment guidelines stipulate that an additional 5 million individuals need treatment immediately. Although 2008 saw the highest levels of resource allocation for HIV and AIDS yet, donors are now curtailing or flat-lining HIV funding.

An important debate at the conference centred on the question of whether or not the international AIDS community should work to do more with fewer resources, seeking efficiency gains where possible and maximising prevention and treatment efforts? Or should it continue to advocate for increased resources to fight HIV and AIDS, in particular light of the new WHO treatment guidelines as well as recent advances in prevention and treatment technologies?

THE MDG REVIEW SUMMIT AND THE GLOBAL FUND REPLENISHMENT
The Millennium Development Goal Review Summit in September 2010 and the Global Fund Replenishment Meeting in October 2010 present vital opportunities to emphasise the integral links between reaching universal access and reaching the health-related Millennium Development Goals (MDGs). Participants in the conference advocated that both meetings are key mechanisms through which the international community can hold global leaders accountable to the universal access pledge and ensure that HIV/AIDS remains part of the global health agenda.

KEY OUTCOMES AND RECOMMENDATIONS
The following key outcomes and recommendations were the messages which featured most prominently at the XVIII International AIDS Conference in Vienna.

1. **Fully replenish the Global Fund to Fight AIDS, Tuberculosis and Malaria.** Only through a fully funded Global Fund can we reach both universal access and the MDGs in 2015.
2. **Implementation of the Treatment 2.0 platform.** The power of the Treatment 2.0 platform lies in the opportunities for a multitude of different kinds of scaling up, including the principle of treatment as prevention to maximize coverage while driving down infection in the wider population. It also emphasises maximizing the use of new prevention technologies including microbicide gels, male circumcision and the successful prevention of vertical transmission.
3. **Better coordination across diseases and among donors.** Donors and implementers need to work more effectively across disparate disease platforms, recognising the benefits of inter-related approaches and programmes to meeting the health-related MDGs over the next five years.
4. **Mobilise small donations in massive quantities.** Initiatives such as Project (RED) and MASSIVEGOOD are innovative mechanisms which are able to tap into the wider population to mobilise resources for the HIV response. Several speakers, including former US President Bill Clinton, spoke of the potential of such initiatives to mobilise critical additional resources.
5. **“Not doing more with less, but doing more with more.”** While the push for greater efficiencies is imperative, these efficiencies cannot be achieved without increased resources. The international community is currently facing a host of challenges including the global financial recession. In the face of these challenges, the principle of health as a human right must be upheld. No other message at the conference was clearer: preserving this right requires prioritising health and saving lives.
1 Taking Stock

“The dream and hope for universal access came from the will to live coming from those fighting the AIDS epidemic.”

— Reverend Robert Vitillo

At the XVIII International AIDS Conference, UNAIDS launched its Treatment 2.0 Platform and presented outcomes from its comprehensive benchmark survey on what people think globally about the HIV/AIDS epidemic and the response. The survey showed that three decades into the epidemic people in all regions of the world continue to rank AIDS high on the list of the most significant challenges facing the world. However, 43.6% of respondents found that the world has not been effective at responding to AIDS, ranking the availability of funding, stigma and discrimination and the accessibility of affordable healthcare as the principal obstacles keeping the world from a comprehensive AIDS response.

Given these perceptions, what should be the core priorities of the international community in tackling HIV and AIDS in the run up to the Millennium Development Goal Review Summit in September and the Global Fund Replenishment Meeting in October 2010?

1.1 WHERE WE ARE, WHAT WE HAVE ACHIEVED

The conference heard that although progress has been made, new infections still outstrip numbers on treatment by 5 to 2, indicating the scale of the future challenge for both treatment and prevention.

- Coverage expanded rapidly in the past few years with an estimated 5 million people on treatment as opposed to fewer than 500,000 in 2003; this represents a twelve-fold increase in access to treatment in six years.
- Antiretroviral therapy coverage in low and middle-income countries is now 42% and coverage in Sub-Saharan Africa was approximately 44% in 2008.
- In 2008, 21% of pregnant women received an HIV test, up from 15% in 2007.
- 45% of pregnant women living with HIV received antiretroviral treatment to prevent mother-to-child transmission (PMTCT).
- 275,000 children under age 15 received antiretrovirals (ARVs) in low and middle income countries at the end of 2008, up from 198,000 in 2007; ARV coverage for children was estimated to be 38%.
- In Sub-Saharan Africa, the retention of people receiving ART was 75% at 12 months following initiation, and 67% at 24 months.
- The availability and uptake of HIV counselling and testing services increased in 2008 with the total number of health facilities providing HIV testing increasing in 66 low and middle-income countries by approximately 35%, from 25,000 in 2007, to 33,600 in 2008.
1.2 OUTCOMES OF KEY INTERNATIONAL INTERVENTIONS

Between 2002 and 2008, commitments and disbursements for the HIV response from high-income countries increased by more than five-fold. Overall commitments in HIV funding from high-income countries totalled USD 8.7 billion in 2008, up from USD 6.6 billion in 2007.9

The Global Fund to Fight AIDS, Tuberculosis and Malaria

From its founding in 2002 through December 2009, the Global Fund Board approved proposals totalling USD 19.2 billion and disbursed over USD 10 billion for HIV, TB and malaria control efforts to over 140 countries.10

The Global Fund estimates that by the end of 2009 Global Fund-supported programmes provided antiretroviral therapy to 2.5 million individuals in 104 low and middle-income countries. By the end of 2011, as an outcome of approved Round 8 and Round 9 proposals and interventions, this number will increase to 3.5 million.11 Results from Global Fund financing show:

- From 2004 to 2009, 790,000 HIV-positive pregnant women received a complete course of ARV prophylaxis to prevent mother-to-child transmission, increasing coverage to 45%.
- In 2009, 340,000 pregnant women in low and middle-income countries received PMTCT treatment through Global Fund grants.12
- The Global Fund is one of the world’s leading multilateral investors in the three diseases and currently provides approximately one-fifth of all HIV funding from donor countries.
- The Global Fund disbursed a cumulative total of USD 5.7 billion for HIV programmes by the end of 2009 and to date, the Global Fund has raised over USD 21 billion.13

PEPFAR

The US President’s Emergency Plan for AIDS Relief (PEPFAR) was the largest contributor to the AIDS response in 2008 accounting for more than 51.3% of disbursements by donor governments.14

- PEPFAR worked to reduce AIDS mortality by 10.5% from 2004 to 2007, averting an estimated 1.2 million deaths.15
- PEPFAR provided financial support for approximately 2.4 million people on ARVs by the end of September 2009.
- Between 2006 and 2008 PEPFAR-funded programmes initiated an average of 49,000 individuals on treatment every month.
- PEPFAR provided care for nearly 11 million people affected by HIV/AIDS, including 3.6 million orphans and vulnerable children as of September 2009.
- PEPFAR directly supported PMTCT programmes that allowed nearly 100,000 babies of HIV-positive mothers to be born HIV-free in 2009.
The Global Health Initiative (GHI)
In May 2009, the US President Obama’s administration launched a six year (2009 to 2014) USD 63 billion health strategy to address global health challenges including child and maternal health, family planning and neglected tropical diseases. The Initiative provides USD 51 billion to the re-authorisation of PEPFAR, and an additional eight countries have been selected as the first set of GHI countries.

The World Bank
The World Bank expanded its financial and technical support for HIV programmes providing loans as well as grants in both low and middle-income counties.

The Multi-Country HIV/AIDS Program for Africa (MAPs) committed more than USD 1.8 billion in 35 countries and overall HIV-related cumulative funding totalled more than USD 3.1 billion from 1989 to July 2009.\(^1\)

The Clinton Health Access Initiative
The Clinton Health Access Initiative (CHAI) was established in 2002 by former US President Bill Clinton to address the limited access to treatment by individuals in low-income settings. It has focussed primarily on improving market dynamics for medicines and diagnostic equipment, lowering the overall cost of treatment, helping governments to improve health systems and to develop human resource capacities to deliver treatment effectively.

- CHAI negotiated ARV price reductions with 8 suppliers on over 40 formulations and negotiated significant price reductions with 12 suppliers for 16 HIV/AIDS diagnostic tests.
- CHAI reduced the price of first-line treatments by 50%, paediatric medicines by 90% and second-line HIV/AIDS medicines by 30% in low-income countries.\(^2\)

UNITAID
UNITAID was established in 2006 to mobilise new sources of finance for drugs and diagnostics to combat HIV, tuberculosis and malaria. UNITAID has raised USD 407 million through air ticket purchase levies and budget support from 29 countries.

- By the end of 2009, 375,000 adults and children were receiving second-line ARVS or paediatric ARV formulations with UNITAID support.
- UNITAID engaged the Clinton Health Access Initiative to negotiate drug prices on its behalf.
- In 2010 UNITAID’s board agreed to establish a patent pool mechanism to simplify the administration of voluntary licensing and to aid the creation of a greater range of low-cost fixed-dose ARV combinations for low and middle-income countries.
1.3 OUTCOMES OF THE G8 AND G20 SUMMITS, 2010

In 2010, the G8 and G20 Summits took place in Canada with the themes *Recover and New Beginnings*. The G8 Summit discussions focussed primarily on aid and development and the G20 conversely focussed on financial and economic affairs including trade, banking and fiscal policies. Both of these Summits represented key opportunities for global leaders to reaffirm their commitment to promises made to the international community.

**The G8 Summit**

The G8 Summit held in June 2010 launched the *Muskoka Initiative*—a new initiative for maternal and child health. The *Muskoka Initiative* has mobilised a total of USD 7.3 billion. This includes USD 5 billion to support health care systems in low-income countries over the next five years and to accelerate progress towards both MDG 4 and 5 to significantly reduce the number of maternal, newborn and under five child deaths in developing countries. It raised an additional USD 2.3 billion with the support of the governments of the Netherlands, New Zealand, Norway, Republic of Korea, Spain and Switzerland, as well as the Bill and Melinda Gates and UN Foundations.

Many would argue that the G8 leaders failed to meet the previous G8 commitment in Gleneagles to increase aid by USD 50 billion and to double aid to Sub-Saharan Africa, citing a shortfall of between USD 10 and 20 billion. The G8 members reaffirmed their commitment to reaching the targets of universal access for HIV and AIDS, underscoring the necessity to make the Global Fund Replenishment in October 2010 a success. However, the G8 failed to set a new target date for its achievement and did not disclose the resources needed to make the commitment a reality.

**The G20 Summit**

The principal priority for the G20 Summit in June 2010 was to safeguard and strengthen the economic recovery and to lay the foundation for strong, sustainable and balanced growth. A core outcome of the summit was commitments made by the G20 countries to boost demand and rebalance growth, strengthen public finances and make financial systems stronger and more transparent. Many global health stakeholders were hopeful that the G20 Summit would provide a significant platform and support for an international Financial Transaction Tax (FTT). However, progressive financial policies on banking reform and FTTs were not agreed upon during the Summit. The G20 Summit re-emphasised its previous commitment to fulfilling its *Framework for Strong, Sustainable and Balanced Growth* agreed to at the Pittsburgh Summit in 2009.

**The African Union Summit**

Investing in the health of women and children was the focus of the high-level Summit of the African Union (AU) held 25-27 July 2010 in Kampala, Uganda. The meeting highlighted progress and challenges in advancing the MDGs 4 and 5 to reduce child mortality and improve maternal health.

AU Member States committed ten years ago to scale up their national budget allocations for health to at least 15%, however only three countries are currently meeting this goal. Overall, the AU Summit was unable to mobilise additional resources to reach the commitments made under the Abuja Declaration in 2000, referring to a necessity to “enhance domestic resources” but without committing to a specific, time bound increase in domestic investments in health.
1.4 THE RESPONSE SHOULD NOT FALTER OR RETREAT NOW

This status report on the global response demonstrates that while the international community has made great progress in scaling up treatment and prevention, there is still a long way to go if universal access by 2015 is to be achieved.

In particular, the treatment gap is still growing. New WHO guidelines emphasise that earlier treatment is more likely to prolong productive life, reduce maternal and child mortality, and reduce onward transmission.

But putting into practice these recommendations will require an amplified response to the epidemic, not retreat or a slowing of the pace of treatment scale-up.

The next section of this report discusses the challenges to achieving universal access, and the extent to which waning political will and a failure to meet previous promises are affecting progress.
2 Challenges to Achieving Universal Access

2.1. THE CURRENT ECONOMIC CLIMATE AND FINANCIAL RECESSION

A key theme among speakers at the XVIII International AIDS Conference was the challenge of the economic climate and its impact on the international community’s ability to reach universal access. UNAIDS and the World Bank perceive that the current economic crisis is more global in scope and severe in consequences than any other period of economic turmoil since the Great Depression of the 1930s. Given that many national AIDS efforts rely significantly on domestic public spending, programs in prevention, care and treatment are most at risk.

In the presentation “HIV/AIDS Funding and Economic Recession: A Call for Visionary Leadership,” the Institute for Democracy in Africa (IDASA) reported that there is considerable concern over donor retreat and backtracking on international commitments to scale up in order to reach universal access.

- IDASA highlighted that in 2009-2010 Médecins Sans Frontiers (MSF) conducted field analyses in eight countries in Sub-Saharan Africa which indicated a trend towards donor retreat, with donors increasingly voicing concern regarding the cost, sustainability and perceived priority of HIV/AIDS within the context of a reduction in overall resources.
- Principal donors including PEPFAR, the World Bank, UNITAID and the Global Fund are all experiencing funding reductions or failing to increase funding in line with needs.
- PEPFAR’s budget under US President Obama’s Global Health Initiative (GHI) will currently cover six instead of five years of funding, with only USD 366 million in new money for PEPFAR for FY2010.
- PEPFAR reduced its budget for ARV treatment for the first time in 2009, from USD 1.56 billion in 2008 to USD 1.38 billion in 2009 under the GHI, reducing the allocation for ARV medicines by 17%.
- Since 2009, contributions to the Global Fund from its other major donors have also remained static, with recent announcements from the Netherlands, Ireland and the United States that their contributions will be reduced.
- The World Bank estimates that the cumulative effect of a diminished scale-up effort over five years would be approximately 10 million deaths and 14 million newly infected individuals.

2.2. CURRENT CHALLENGES IN MEETING THE MILLENNIUM DEVELOPMENT GOALS

While the international community has many successes to be proud of, to date there has been insufficient progress on MDGs 4, 5 and 6 with MDG 5 in particular being the furthest off track. There has been little progress on MDG 4 in Sub-Saharan Africa and insufficient progress in Asia, however many countries are still on track to reach MDG 4 to reduce child mortality.

In her presentation “HIV and MNCH: Can we do one without the other?” Anne Starrs of Family Care International reported that maternal mortality rates in Sub-Saharan Africa and South Asia remain high with little improvement in coverage of deliveries by skilled birth attendants —there were only 23 counties on target to achieve MDG 5 in 2015.
The Millennium Development Goals

- **Goal 1:** eradicate extreme poverty and hunger
- **Goal 2:** achieve universal primary education
- **Goal 3:** promote gender equality and empower women
- **Goal 4:** reduce child mortality
- **Goal 5:** improve maternal health
- **Goal 6:** combat HIV/AIDS, malaria and other diseases
- **Goal 7:** ensure environmental sustainability
- **Goal 8:** develop a global partnership for development

HIV is at present the leading cause of death for women of reproductive age globally with 682,000 (19.2%) followed by 516,000 for maternal conditions and tuberculosis with 228,000 deaths annually.

- For MDG 6, it is estimated that 33 to 46 million individuals are living with HIV, 67% of which are in Sub-Saharan Africa and 50% of which are young women.
- In his presentation “HIV and the Health MDGs: Critical Interactions, Policy Evolution and Implications,” Dr Gottfried Hirnschall reported that there were approximately 2.7 million new HIV infections in 2008, 10 million people without access to antiretroviral therapy, 0.5 million cases of multi-drug resistant tuberculosis, 300,000-800,000 maternal deaths and 8.8 million deaths in children under five years.

2.3. **THE NEED FOR EVIDENCE-BASED HARM REDUCTION**

In the lead up to the XVIII International AIDS Conference key stakeholders of the international community, including leading scientific and health policy organisations, committed to improving community health and safety by calling for the incorporation of scientific evidence into drug policy.

The scientific consensus on the need for drug-related harm reduction based on the latest scientific evidence is set out in the Vienna Declaration, published prior to the conference.

The Vienna Declaration stipulates that “the criminalisation of illicit drug users is fuelling the HIV epidemic and has resulted in overwhelmingly negative health and social consequences.” Moreover, reflecting the theme of “Rights Here, Right Now,” the Vienna Declaration is rooted in the understanding that global drug policy must respect the human rights of people who use drugs in order for it to be effective.

- Across the different regions, injecting drug use continues to account for a substantial proportion of new infections. For example, in Sub-Saharan Africa injecting drug use accounts for an estimated one in three new cases of HIV, and in Eastern Europe and Central Asia injecting drug use is the primary route of new infections.
- Legal barriers to vital prevention services such as needle programmes and opioid substitution therapy mean hundreds of thousands individuals continue to be infected with HIV and Hepatitis C every year.
The Vienna Declaration called on governments and international organisations to:
• Review the effectiveness of current drug policies
• Implement a science-based public health approach to address illicit drug use
• Scale up evidence-based drug dependence treatment options
• Abolish ineffective compulsory drug treatment centres
• Support and scale up funding for drug treatment and harm reduction measures endorsed by the WHO.

From September 2010, there were over 16,638 signatures to the two page declaration.
3 The Way Forward: Scaling Up Resources to Reach Universal Access

“We cannot give up on universal access because that is giving up on life and human rights.”
— Dr Aaron Motsoaledi, Minister of Health South Africa

At present, there are approximately 5 million individuals receiving treatment for HIV, yet this represents only one-third of the individuals who need treatment urgently. There was broad consensus among participants at the conference that without additional resources to fight AIDS gains made particularly in the last six years will be undermined.

UNAIDS estimates that USD 28 billion to USD 50 billion is needed globally every year from 2010 to 2015 in order to progressively reach Universal Access targets for HIV/AIDS by 2015.

The international community must concentrate its funding within the most effective funding mechanisms, for example the Global Fund. Moreover, countries like South Africa are moving from reliance on donor funding to significantly increase domestic funding for HIV and AIDS over time. There are also widespread and increasing calls for Financial Transaction Taxes which have the potential to amass significant resources for health among a broad spectrum of countries. Moreover, private spending and donations among individuals such as Project RED and MASSIVEGOOD has the potential to raise a massive amount of money in small amounts from a large number of people for global health priorities.

3.1. THE REPLENISHMENT OF THE GLOBAL FUND TO FIGHT AIDS, TUBERCULOSIS AND MALARIA

At the XVIII International AIDS Conference in Vienna, political leaders and activists advocated for the full replenishment of the Global Fund in October 2010. This will require USD 20 billion on the part of donors and the international community. The Global Fund is recognised by the international community as an effective mechanism through which to disburse large amounts of resources rapidly, so the replenishment of the Global Fund becomes a key factor to reaching universal access in 2015.

During the session “No Resources, No Results” the Executive Director of the Global Fund, Dr. Michel Kazatchkine, described the three scenarios developed by the Global Fund for the resource replenishment period of 2011 to 2013. They provide scenarios for funding of USD 13 billion, 17 billion and 20 billion, each of which allow for the continuation of existing programmes. Each has different implications for scale up and for achieving universal access and the health-related MDGs. Many argued that only through the achievement of Scenario 3 (USD 20 billion) could we meet the targets of universal access and achieving MDG 6 for 2015.
**Scenario 1 USD 13 billion:** would allow for the continuation of funding of existing programmes however new programmes could only be funded at a significantly lower level than in recent years. This scenario does not represent an estimation of the volume of high-quality proposals expected to be submitted. Rather, it indicates the level of demand that could be met by the foreseen resources.

**Scenario 2 USD 17 billion:** would allow for the continuation of funding of existing programmes. In addition, it would allow for funding of new proposals at a level that comes close to that of recent years. This would allow current trajectories of progress to be preserved.

**Scenario 3 USD 20 billion:** would allow for the continuation of funding of existing programmes. In addition, well-performing programmes could be scaled up significantly, allowing for more rapid progress towards achievement of the health-related Millennium Development Goals.  

3.2. **NATIONAL GOVERNMENT SPENDING ON AIDS**

Some donors and advocates argue that many countries affected by HIV/AIDS are currently over-reliant on donor funding and could feasibly raise domestic spending, particularly in middle-income settings. UNAIDS estimates that governments should allocate between 0.5 and 3% of government revenue on HIV, depending on the HIV prevalence level of the country.

In the presentation “HIV/AIDS Funding and Economic Recession: A Call for Visionary Leadership” IDASA presented an analysis of HIV/AIDS funding in Eastern and Southern Africa. The study concluded that:

- Resource allocations for health strengthening activities by national governments are low. More than 80% of HIV/AIDS programme activities are funded by donor governments.
- Most countries in Sub-Saharan Africa have more than half of their funding on HIV/AIDS provided by donor governments, with Zambia providing 15% domestic funding, Ghana 21% and Mozambique 15%.
- Botswana currently leads the world in domestic spending on HIV; it devotes over 4% of all government revenue to HIV prevention and treatment.

3.3. **INNOVATIVE FINANCING MECHANISMS**

During the plenary “Towards a Paradigm Shift in AIDS Prevention,” Executive Director of UNAIDS, Michel Sidibé emphasised the potential of innovative financing initiatives in helping the international community mobilised the resources it needs to effectively reach universal access.

- At present, several countries and key stakeholders are mobilising campaigns to advocate for increased levies on the financial sector in order to lead the way to long-term funding solutions to reach key international commitments. In fact most G-20 countries already tax some financial transactions. The broadest application is in Argentina, which taxes payments into and from current accounts, and in Turkey, which taxes all receipts of banks and insurance companies. This demonstrates that a tax on the financial sector is feasible and can help raise a considerable amount of new resources to finance universal access and broader health initiatives.
• In 1999, Zimbabwe introduced an AIDS levy of 3% on all taxable income.
• In the UK a 0.5% Stamp Duty on share transactions raises more than GBP 3.2 billion per annum, applying to domestic stock trades and trades of UK-based companies on exchanges in other countries.
• France, Germany, Belgium, Hungary and the EU are supportive of the introduction of a new Financial Transaction Tax across the G8 countries and France and Germany in particular are advocating for a global FTT.
• The presentation “When Does HIV Funding Strengthen Health Systems?” indicated that an international FTT at an average rate of 0.01% could raise as much as USD 40 billion per year.
• The Robin Hood Tax campaign has mobilized in many countries – France, Germany, the UK, Canada, and Australia - calling for the introduction of levies to raise additional resources from the financial sector.
• UNITAID demonstrates how national air ticket levies can generate substantial funds to support global public goods; currently 29 countries contribute to UNITAID every year.

3.4. **GLOBAL SPENDING, GLOBAL GOOD**

There are many effective mechanisms to mobilise resources among the general population through the purchase of consumer goods. In his opening plenary to the conference in Vienna, former US President Bill Clinton commended both Project (RED) and MASSIVEGOOD as noteworthy examples of how campaigns to mobilise small amounts of funding from large numbers of individual consumers are increasingly becoming potential mechanisms to bridge the funding gap to achieve universal access and the health-related MDGs for 2015.

**PROJECT (RED)**

Project (RED) was launched in 2006 in partnership with global brands such as Nike, Starbucks, Converse, Apple and Gap to generate resources for the Global Fund through individual consumption. Since its inception (RED) has mobilised USD 150 million for the Global Fund to combat HIV and AIDS programmes in Sub-Saharan Africa. The campaign allows individual consumers themselves to be involved in mobilising a global AIDS response.

**MASSIVEGOOD**

MASSIVEGOOD began in the US in 2010 through a USD 2 contribution to a major global health cause every time an individual purchases an airline ticket, reserves a hotel room or rents a car. The campaign represents a significant collaboration between the travel and tourism industry and global health organisations fighting AIDS, tuberculosis, malaria and maternal and child health in low-income countries. Key global health partners of MASSIVEGOOD include the Global Fund, the Clinton Foundation, UNICEF, the World Health Organisation, with funds allocated through UNITAID.
3.5. NEW OPPORTUNITIES FOR EFFECTIVE PREVENTION

“Universal access is about social justice and the distribution of opportunity. Universal access cannot happen if we do not bring innovation.”
— Michel Sidibé, Executive Director UNAIDS

There is growing evidence that the earlier an individual begins treatment, the better the implications for the individual’s own recovery. There is also growing evidence that earlier treatment will lower infection levels in the overall population, in particular in settings with general epidemics. In fact, as the number of individuals on treatment grows, new HIV infections tend to fall.

Key items of evidence include:

- A recent study by the University of Washington which examined 3400 serodiscordant heterosexual couples in seven countries in Sub-Saharan Africa. The study’s key findings indicate that when the HIV-positive partner was on treatment the HIV transmission rate was 92% lower.

- A population-based study of all people treated in British Columbia, Canada, from 1996 to 2009. The study found that HIV diagnoses fell significantly during periods when HIV treatment enrolments increased. The outcomes of the study suggest that community viral load can be a key driving force of new HIV diagnoses and can be effectively adjusted through expansion of ART coverage within medical guidelines.

In the conference plenary “Towards a Paradigm Shift in AIDS Prevention” Dr Michel Sidibé of UNAIDS and former President of the International AIDS Society (IAS), Dr. Julio Montaner demonstrated that the prevention impact of antiretroviral therapy has become a powerful argument for increasing resources to fight HIV. By preventing an accumulating burden of new infections in the future, expanding treatment today becomes financially sustainable.

Treatment as Prevention

Since 1991, the international community has recognised that effective antiretroviral therapy can help to prevent HIV transmission. This has been the case for vertical transmission in the prevention of mother-to-child transmission (PMTCT). However, recently the broader implications and impact of Antiretroviral Treatment (ARV) has become better understood. Antiretroviral therapy reduces viral levels in the body and reduces the risk of transmitting HIV.

A large number of conference presentations addressed the central question of how treatment can enhance prevention efforts. Key points included:

- Geoff Garnett in his presentation “Exploring the Potential Impact of ART in Reducing HIV Transmission” argued that good treatment coverage among those with CD4 cell counts of less than 200 could avert approximately 25% of new infections, and a further 15% of infections if coverage extended to those with CD4 counts less than 350.

- In “Potential Role of PEP, PrEP and ART for HIV Prevention among men who have sex with men,” Frits van Griensven highlighted the strong association between mean community viral load, total community viral load and reduction in newly identified HIV cases from 798 in 2004 to 434 in 2008 in a study conducted among men who have sex with men (MSM) in San Francisco.
In his presentation “New Concepts in HIV/AIDS Pathogenesis: Implications for Interventions” Dr. Anthony Fauci argued the implications for early administration of ART, including the reduction in the size of the HIV viral reservoir, the preservation of immune function, the health benefit to the individual as well as decreased transmission in the community.

In the presentation “Close the Gap: Prospective Game Changer and Countering the Retreat from HIV Treatment Scale-Up” MSF highlighted that treatment as prevention additionally becomes a vital tool in bringing down the overall healthcare costs of treating HIV/AIDS as treating people earlier will also mean cost savings as fewer people present with opportunistic infections related to HIV, and saves resources as less individuals need to present to clinical health settings over time.

**Prevention Technologies**

Cumulative data on the prevention of vertical transmission, emerging data on male circumcision and recent advancements in microbicide gels provide encouraging evidence of effective prevention methods for combating HIV. While treatment as prevention has become established orthodox practice in the area of the prevention of mother-to-child transmission, the application of microbicide gels and the practice of male circumcision has become an additional mechanism through which HIV incidence, combined with other prevention methods, can be reduced.

**Prevention of Mother-to-Child Transmission**

In 2008, there were approximately 430,000 new paediatric infections and 390,000 deaths attributed to paediatric HIV, more than 90% of which could be attributed to vertical transmission. Women with more advanced disease are much more likely to transmit HIV to their infant, underlining the need to maximise treatment coverage to women who need it for their own health.

- Dr Elaine Abrams in her presentation “Eliminating Vertical Transmission: Rights Here, Right Now,” reported that although the uptake of testing and provision of ARV prophylaxis in pregnant women has increased, coverage remains low. Only 21% of pregnant women received an HIV test in 2008.
- Furthermore, only 45% of HIV positive women in low and middle-income countries received ARVs in 2008, up from 35% in 2007.47
- The key factors identified for increasing uptake and success in decreasing vertical transmission are the effective use of maternal and child health services, the national scale up of services for vertical transmission prevention and the implementation of more comprehensive programming—including CD4 testing, more efficacious regimens, infant follow-up and early infant diagnosis.48

There are nevertheless successful examples to be followed in the area of PMTCT:

- The vertical transmission rate is less than 5% in Botswana due to comprehensive scale-up of ART and voluntary testing and prevention services
- An assessment of early transmission among children attending immunization clinics in KwaZulu Natal, South Africa found only 7% infection rates in 2008-2009 versus 21% in 2004-2005.49
Much greater efforts to integrate PMTCT interventions into maternal-child health services are needed. Antiretroviral prophylaxis is a highly effective intervention that could lead to the virtual elimination of vertical HIV transmission, but it can only have maximum impact if all pregnant women are tested, if all women with HIV receive CD4 monitoring and if all women take the prescribed antiretroviral drugs.

**Male circumcision**

In his plenary session “Building on Success: A Roadmap for HIV Prevention,” Bill Gates emphasised that male circumcision is increasingly becoming recognised as an effective tool among men to reduce the risk of HIV infection, especially in countries with higher rates of heterosexually transmitted infections and with lower levels of male circumcision.

- Three randomized control trials carried out in Sub-Saharan Africa to assess the impact of male circumcision on acquiring HIV among heterosexual men showed a 60% reduction in the risk of acquiring HIV.50
- The 2007 WHO/UNAIDS Technical Consultation on Male Circumcision and HIV Prevention recommends that male circumcision should be scaled up as part of a comprehensive, integrated HIV prevention package in particular in countries with HIV prevalence levels in a generalised epidemic above 15.51
- Kenya, for example, aims to increase the proportion of circumcised men from 84% to 94% on a nationwide basis. This will require 150,000 male circumcisions per year over five years.52

**Advances in Microbicides**

Arguably the biggest news from the International AIDS Conference in Vienna was the encouraging result from the CAPRISA trial of a female microbicide gel to block the transmission of HIV, which came after a series of failed microbicide trials.

In the session “Using Antiretrovirals to Prevent HIV: Implications of the Outcome of the CAPRISA 004 Tenofovir-Gel Microbicide Trial,” South African researchers reported that a vaginal microbicide gel containing the antiretroviral drug tenofovir had reduced the risk of infection by 39% during two and half years of use. Among women who used the gel more than 80% of the time, HIV incidence was 54% lower than in those who did not use the new gel. Even among women who used the gel less than half the time HIV incidence was reduced by 28%. Further trials are now underway or planned to confirm this result, and positive results could allow a new prevention method, controlled by women, to be made widely available within 5-7 years.
Combination Prevention

The utilization of treatment to further prevent HIV infections in the wider population can be an effective tool, especially in combination with other proven and effective prevention methods. There are three forms of combination prevention which are currently being applied to varying degrees to effectively combat HIV and AIDS in a range of settings. They are:

**Type 1:** The common strategy of applying two or more prevention strategies, for example needle and syringe programmes and opiate replacement for injecting drug users.

**Type 2:** Combining diverse strategies to fit the needs of diverse sub-groups in the population, including strategies for MSM, transgender, injecting drug users, PMTCT, and discordant couples.

**Type 3:** Strategic combinations of biomedical, behavioral and structural approaches to address key causes of HIV risk and vulnerability for a particular population, for example working with MSM and trans-gender people, with behavioral change promotion, STI treatment, decriminalization and community mobilization.

- In his presentation “Combination HIV Prevention: Crafting a New Standard for the Long-Term Response to HIV,” Dr. Carlos Caceres argued that 54% of today’s HIV prevention expenses go to interventions focussed on the general population, with the prevention expenses for the most at-risk populations below 7% of total prevention spending in low-level and concentrated epidemics, with MSM as the least attended to group.
- Furthermore, he stipulated that in generalised epidemics, less than even 1% of funding is going to HIV prevention among the most vulnerable groups.
- Dr Caceres concluded that by applying a range of prevention methods in a given setting, which together are able to address not only behavioural, but also the structural, determinants of the epidemic such as the legal environment, and social and cultural norms (gender inequalities, HIV-related stigma), the probability increases for averting greater numbers of individuals at risk of acquiring HIV.

The AIDS2031 modelling working group have made model projections for the possible course of the epidemic looking at 22 of the most affected countries in the world, which consequently account for 75% of the global burden of HIV. If the coverage of interventions remains at today’s level, the estimated number of people living with HIV would be approximately 45 million.

However, with a combination of scaled up prevention interventions— including circumcision, counselling and testing, treatment and community mobilization in generalised epidemics, as well as a focus on condom use and harm reduction among those at greatest risk in more concentrated epidemics, the number of new infections each year would be closer to 800,000, and by 2031 there would be 19 million overall. This means that over the next couple of decades 25 million infections could be averted.
Evidence for Integrated Approaches

Some countries are taking the notion of combination prevention even further through an integration of multi-disease programmes which consider the impact, for example, of TB and malaria infections on HIV. Countries such as Kenya have been able to scale up access to HIV testing through this integrated multi-disease approach with the acknowledgement that HIV diagnosis is critical for prevention and treatment, while equally the prevention of co-infections such as malaria and diarrhoea delay the effectiveness of disease programmes.

- In the presentation “Scaling up access to HIV testing through an integrated multi-disease campaign is feasible and cost saving,” Eric Lugada demonstrated that this particular strategy relies on the method of testing along with the provision of free health commodities and community mobilisation which specifically provided individuals with a free HIV test, as well as a free mosquito net and water filter.
- This integrated campaign works to address a multitude of health problems to achieve its national objectives in an innovative way with the added benefit of potentially being able to reduce disease programme costs by up to one half in some settings.

Treatment 2.0

The new Treatment 2.0 platform launched at the XVIII International AIDS Conference in Vienna, integrates all of the above approaches with an emphasis on preventing new HIV infections in a way which is smarter, faster and better. The Treatment 2.0 platform is based on the notion that the international community can reduce new HIV infections by up to one-third if there is a significant change in how ARVs are provided and more importantly if global leaders meet international commitments of universal access to treatment.

The Five Pillars of Treatment 2.0:

Pillar 1. Creating better treatment and diagnostics: This includes improving the effectiveness and ease of use of ARVs and lowering their side-effects

Pillar 2. Treatment as Prevention: This supports the notion that treatment can become part of a combination prevention strategy while maximising treatment coverage

Pillar 3. Stop cost being an obstacle: Even though significant gains have been made in reducing the cost of ARV treatment, the cost of HIV treatment programmes continue to rise, in particular in settings where people are obligated to move to second and third-line treatment regimes

Pillar 4. Improve uptake of HIV testing and linkage to care: Addressing this ongoing challenge involves learning from and scaling up successful models of partnership between health service providers and community-based service providers

Pillar 5. Strengthen community mobilisation: Community organisations have proven that they are able to lead and manage a comprehensive response to HIV, therefore strengthening community mobilisation efforts are essential.

Together these pillars provide a fundamental framework to shape the current response to scaling up HIV treatment, prevention and care for universal access.
3.6 INTEGRATION OF THE MILLENNIUM DEVELOPMENT GOALS

To reach universal access by 2015, the health-related MDGs must also be met, in particular as the implications of HIV and AIDS on child mortality and maternal health are considerable. Many initiatives such as the Global Fund and PEPFAR, as well as the Global Alliance for Vaccines and Immunisation (GAVI), the World Bank, the Secretary General’s Joint Action Plan for Women and Children’s Health, and the G8 Muskoka Initiative, have aligned their indicators in order to account for progress towards both universal access and the health-related MDGs, in particular MDGs 4, 5 and 6.\textsuperscript{57}

These initiatives operate with the common understanding that to respond to one MDG target without taking advantage of the delivery platforms being made available to respond to the other is a missed opportunity. By combining the HIV and tuberculosis platforms and the maternal and child health/family planning platforms, this will allow for bringing the three MDGs closer together, and consequently increase the probability of meeting these international commitments.

MDGs 4, 5 and 6: Can we do one without the other?

The debate about how to invest finite donor resources is often framed in terms of either/or choices such as HIV treatment versus prevention, maternal and child health versus HIV and AIDS or the strengthening of health systems versus community systems. However, successful attainment of the eight Millennium Development Goals will require the international community to address a range of health challenges simultaneously.

- In the presentation “HIV and MNCH: Can we do one without the other?” Anne Starrs demonstrated that over the last three decades there has been increasing recognition that the impact of HIV and AIDS is having a devastating effect across a wide range of health outcomes, and in particular is responsible for the weakening of health systems in many countries.

In his opening plenary “Universal Access: Treatment and Prevention Scale Up,” Dr Aaron Motsoaledi, Minister of Health for South Africa, explained that in South Africa, where HIV prevalence is currently 29%, it is clearly recognised that maternal and child mortality are HIV-related with 43% of maternal mortality attributable to HIV infection. Among pregnant HIV positive women, mortality has increased ten-fold in comparison to those who are negative and moreover, 57% of deaths of children under age 5 in 2007 were as a result of HIV.\textsuperscript{58}

Minister Motsoaledi said the government of South Africa has recognised that without a “frontal attack” on HIV and AIDS which has brought the health system to near collapse, none of the MDGs will be achievable in the country. To meet this immediate challenge, the 2011 South African national strategic plan specifies that it will reduce the number of individuals infected with HIV by half, providing effective treatment and care to 80% of the individuals who urgently need it. This strategy is accompanied by a large-scale national testing campaign to test 15 million South Africans by June 2011.
3.6. RIGHTS HERE, RIGHT NOW: MAKING HUMAN RIGHTS A PRIORITY

“People will only get and stay on treatment if we devote resources to human rights. I believe the situation remains as urgent today as it was ten years ago.”

-Dr Michel Kazatchkine, Executive Director of the Global Fund

Human rights are an unresolved issue in the AIDS response and a lack of a human rights perspective may lead to programme failure. The XVIII International AIDS Conference articulated the theme “Rights Here, Right Now” in recognition of the fundamental role of human rights to reach universal access targets and in achieving the Millennium Development Goals in 2015.

Placing Human Rights at the Forefront

Consideration of human rights is a necessary element of any successful HIV programme. For example, discrimination on the basis of HIV status, gender, sexual orientation, drug use or sexual practices deters people from accessing prevention services and makes them more vulnerable to infection. This is exacerbated where discrimination is institutionalized through law and policy.

Tackling HIV requires political leadership on issues of human rights but in high-prevalence settings, many leaders do not see HIV and AIDS as a priority.

Human Rights and the Protection of Vulnerable Groups

In his presentation “Combination HIV Prevention: Crafting a New Standard for the Long-Term Response to HIV,” Dr Carlos Caceres highlighted that good prevention planning starts with a human rights analysis to understand people’s needs and constraints in programme design, in particular where vulnerable and marginalized groups are involved. It is not sufficient to just plan to ‘protect human rights’ at implementation. He demonstrated that:

- Condom use integrated into programming among sex workers in Asia without consideration of human rights issues led to abuse of the sex workers and overall programme failure.
- The presentation “Political and Economic Challenges for Achieving Universal Access,” underscored that police brutality is considered as one of the principal challenges for injecting drug users (IDUs) in Odessa. Approximately one-fourth of IDUs report being beaten and targeted by police. A recent study demonstrated that if the practice of police brutality were removed in Odessa, it would result in up to a one-fifth reduction in HIV incidence over the next five years. Punitive laws such as those in Odessa need to be eradicated as the legal environment pushes these groups even further into the margins making access to testing and treatment a considerable challenge.
- In the poster presentation “Human Rights Costing of ART for Prevention,” Reuben Granich demonstrated that the protection of human rights in expanded ART programmes is obligatory and only a small percentage of overall costs, showing 0.9% of total programme costs. The presentation also highlighted that measuring the cost and impact of human rights interventions is important for achieving universal access.
- A joint study by International Center for Research on Women (ICRW) and the London School of Hygiene and Tropical Medicine (LSHTM) also modelled the impact of stigma on PMTCT interventions predicting that stigma and discrimination reduces the impact of PMTCT programmes. More importantly, in high-capacity settings such reduction in impact could lead to 55% additional peri-natal infections.
Human Rights and Voluntary Counseling and Testing (VCT)

While over the years the international community has learned that it is a human rights imperative to know one’s HIV status, asking people to test in environments where people are still stigmatised and discriminated against could also be considered a violation of human rights.

The session “Novel Approaches to HIV Testing,” stipulated that HIV programming is increasingly requiring the scaling up of HIV testing methods. In addition, donors and policy makers are recognising that without universal access to testing, universal access to HIV treatment is an unlikely scenario.

- Approximately 17 million individuals in Sub-Saharan Africa have undiagnosed cases of HIV infection and globally only about 40% of people living with HIV know their status.\textsuperscript{65} Extensive efforts are underway to not only expand HIV testing but to also ease the use of testing technology.\textsuperscript{66}
- Implementers are increasingly utilising innovative methods to reach out to large numbers of individuals in ways which do not exacerbate stigma and discrimination. For example, population-based door-to-door testing and integrated multi-disease testing models as discussed in the previous section in Kenya.
4 Key Policy and Advocacy Recommendations

“This is not the end, not even the beginning of the end, but only the end of the beginning.”
— Former President Bill Clinton

The next five years are key opportunities to reach universal access to HIV prevention, treatment and care to millions of individuals affected by HIV and AIDS globally and to meet the Millennium Development Goals for 2015.

The following recommendations emphasise some of the key advocacy messages communicated during the XVIII International AIDS Conference in Vienna 2010 as well as the International AIDS Society’s view for reaching these goals quickly and effectively.

**Financing**

- **Fully replenish the Global Fund to Fight AIDS, Tuberculosis and Malaria.** No other message among conference participants was clearer—only through a fully funded Global Fund could we reach both universal access and the MDGs in 2015. This requires supporting the third funding scenario for USD 20 billion during the October 2010 Replenishment for the effective scale-up of well-performing programmes and the continuation of funding for existing programmes.

- **Develop and support innovative financing mechanisms at a global level.** There are increasing calls to tax the banks and financial transactions. We need to ensure that the international community’s key health challenges including HIV, TB and malaria are fully financed. This can happen if we concentrate efforts on securing the introduction of new bank levies and ensuring that a significant proportion of the new resources are channelled to those most impacted.

- **Greater commitment of domestic resources by governments in the worst-affected countries.** Long-term sustainability of HIV prevention and treatment will require greater priority to be given to health, and HIV in particular, within government expenditures. In particular, African Union members need to meet their commitment to devote 15% of their national budgets to health.

- **Mobilise small donations in massive quantities.** Initiatives such as Project (RED) and MASSIVEGOOD are innovative mechanisms which are able to tap into the wider population to mobilise resources for the HIV response. These initiatives allow the individual to contribute small amounts of money to his/her choice of health priority, and have already raised millions to fight AIDS; more importantly, they have the potential to raise hundreds of millions more.

- **“Not doing more with less, but doing more with more.”** While the push for greater efficiencies is imperative, these efficiencies cannot be achieved without increased resources. The international community is currently facing a host of challenges including the global financial recession. In the face of these challenges, the principle of health as a human right must be upheld. There was unquestionable consensus at the XVIII International AIDS Conference that preserving this right requires prioritising health and saving lives.
Treatment

- **Implementation of the Treatment 2.0 platform.** The power of the Treatment 2.0 platform lies in the opportunities for a multitude of different kinds of scaling up, including the principle of treatment as prevention to maximize coverage while driving down infection in the wider population; maximizing the use of new prevention technologies including microbicide gels, male circumcision and the successful prevention of vertical transmission. Combining a host of different strategies will have a maximum impact on saving lives.

- **Drive down the cost of treatment delivery in order to maximise the impact of treatment investments.** The cost of first-line ARVs has been dramatically reduced in the last few years as an outcome of Brazil and India’s decision to mass produce generic drugs and changes to pharmaceutical patent laws, with the cheapest first-line drug now costing USD 100 per year. At this stage, the best method to driving down the overall cost of treatment, which is approximately USD 460 per year per patient, is to lower the cost of delivering the treatment, such as through task shifting initiatives and moving treatment delivery from clinical to community settings.

- **The quest for more efficacious, better tolerated, safer and more forgiving ARVs must continue.** The AIDS response requires increased access to better and safer ARVs while ensuring greater coverage, however developing these drugs becomes a challenge in the face of increasing patent protection. Working to provide more efficacious drugs will necessitate international mobilisation to support a patent pool to allow new drugs to become available, which are consequently affordable.

Coordination

- **Better coordination across diseases and among donors.** Donors and implementers need to work more effectively across disparate disease platforms, recognising the benefits of inter-related approaches and programmes to meeting the health-related MDGs over the next five years.

- **Strengthening the advocacy of civil society.** Civil society has worked successfully over several decades to raise public awareness of HIV/AIDS and to mobilise billions internationally to prevent and treat the epidemic. The challenge now is not only to advocate more funding, but to ensure that the resources are channelled to those who need them the most. This requires advocates to call on their national governments to use their own domestic budgets and equally to respond to the rapidly changing dynamics of the sector.

CONCLUSION

The XVIII International AIDS Conference confirmed that in recent years, the HIV response has rapidly scaled up as a result not only of increased bilateral and multilateral funding, but also due to the reduction in the cost of treatment and the application of innovative methods of prevention. Key stakeholders in the HIV response have also adapted to the effective utilisation of additional health-related platforms such as maternal and child health and family planning. The progress and results that have been achieved, while significant, remain below the targets for universal access. Programme scale up based on demonstrated good practice, programme efficiency gains, and the continued call for increased resources to avert millions of infections worldwide, are essential to ensure that universal access to the prevention, care and treatment of HIV and AIDS will be a reality by 2015. The fight for universal access is far from over and the lives of millions of women, men and children hang in the balance, so the IAS will continue to demand a redoubling of efforts to achieve universal access, right here, right now.
Endnotes


3 UNAIDS. Outlook Report 2010, p. 47.


17 CHAI. “What We’ve Accomplished.” http://www.clintonfoundation.org/what-we-do/clinton-health-access-initiative/what-we’ve-accomplished


19 G8 Muskoka Declaration: Recovery and New Beginnings. Muskoka, Canada 25-26 June


27 Family Care International. “HIV and MNCH: Can we do one without the other?” Presentation to the XVIII International AIDS Conference, Vienna 18-23 July 2010.


31 Ibid.

32 IAC Opening Plenary during the presentation “Universal Access: Treatment and Prevention Scale Up.”


36 UNAIDS. Outlook Report 2010, p. 56.


41 IAC Session “Towards a Paradigm Shift in AIDS Prevention.”
