

National responses: turning commitment into action



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Two decades into the HIV/AIDS epidemic, a great deal of experience has been gathered on how to respond effectively to the epidemic. Nationally, leaders are committing themselves and their administrations to fighting AIDS at successive levels, down to, and including, neighbourhoods and community associations. This political commitment is being translated into action as institutional structures are reorganized and mobilized to join the AIDS response. More resources are being deployed. And national efforts are linking up across borders.

Political commitment: where deeds and gestures meet

A mere six years ago, when UNAIDS was beginning its advocacy work with governments in various parts of the world, it was often difficult to draw the attention of top-level political leaders to HIV/AIDS. The pressure of many other priorities and the sheer lack of information meant the epidemic was seen mainly as a medical matter to be handled by health ministries.

Now, however, presidents and prime ministers throughout Africa, the Americas, the Caribbean, Asia and Eastern Europe are publicly displaying personal commitment to the fight against AIDS. They have recognized that AIDS is not just a health issue; it is fundamental to development, progress and security. In Africa, for example, the Heads of State from several countries (including Mali,

Declaration of Commitment

By 2003, ensure the development and implementation of multisectoral national strategies and financing plans for combating HIV/AIDS that address the epidemic in forthright terms [...] (paragraph 37).

United Nations General Assembly Special Session on HIV/AIDS, June 2001, New York

Nigeria, Rwanda, South Africa and Uganda) have come together to form AIDS Watch Africa. An example of peer education at the highest level, this initiative enables members to alert other Heads of State to the threat AIDS poses to development, and to encourage them to tackle the epidemic.

This high-level political commitment has acquired more than symbolic weight. In country after country, rapid advances have been made when presidents and prime ministers took control of the AIDS response,

often chairing the national coordinating bodies dedicated to dealing with the epidemic. But the symbolic value of stirring declarations of commitment is also important, for it sounds the alarm, helps spur people to action, and generates hope among those who might have felt marginalized by a disease few talked about publicly. Ukrainian President Leonid Kuchma, for example, has moved his country's response forward considerably by declaring 2002 his country's 'Year against AIDS'.

Reaching across borders

The understanding of AIDS as a human security issue, along with widespread concern about the negative effects of globalization, has brought home to governments the message that AIDS is truly a global problem that calls for global responses. Political commitments are being made not just at the national, but also at the regional, level.

An example is the Pan-Caribbean Partnership on HIV/AIDS. Launched at the February 2001 meeting of the region's Heads of State, the partnership links the resources of governments and the international community with those of civil society to boost national and regional responses. Operating as part of the Caribbean Community Secretariat (CARICOM), it includes regional partners such as the Caribbean Network of People Living with HIV/AIDS, the Caribbean Development Bank and the University of the West Indies.

Across the ocean, the International Partnership against HIV/AIDS in Africa is harnessing the strengths of its five stakeholder groups (governments, bilateral donors, civil society, the private sector and the United Nations) to advocate enhanced, coordinated efforts to fight the disease. The Partnership encourages the creation of inclusive 'partnership forums' at the country level, and has been instrumental in continent-wide events such as the African Development Forum's discussions of AIDS in 2000, and the Abuja Summit in 2001.

The Indian Ocean Partnership against AIDS, meanwhile, brings together the island nations of Comoros, Madagascar, Mauritius, the Seychelles, and the French overseas territory La Réunion. Centred on the Indian Ocean Commission, the partners have agreed to mobilize resources jointly, advocate the achievement of the UNGASS Declaration of Commitment goals, integrate HIV/AIDS programmes into national development instruments, and reinforce the capacities of nongovernmental organizations, among other action points.

Nongovernmental organizations are also forging regional and international links. In Asia, the Coalition of Asia-Pacific Regional Networks on HIV/AIDS (known as the Seven Sisters), brings together networks representing or working with some of the region's most affected or vulnerable groups, together with service providers and professionals working in HIV/AIDS prevention and care.

Breaking the silence

The involvement of people living with HIV/AIDS is crucial if the barriers of stigma, discrimination and denial are to be overcome. But if they are to choose candour over secrecy, people living with the virus need to have an environment that protects them. For this to happen, leaders have to safeguard fundamental human rights. This may mean reviewing and improving legal instruments, and extending people's access to legal services and information (see 'Focus: AIDS and human rights'). In the Philippines, for example, the 1997 National AIDS Law was developed in consultation with a wide range of stakeholders by the Ministry of Justice. More recently, the Indian Ocean Partnership (see 'Reaching across borders' box) explicitly affirmed the need to respect human rights in order for the HIV/AIDS strategies to succeed.

The commitment of countries' top political leaders must cascade across all levels of government. In that vein, the May 2001 Annual Meeting of Francophone Parliamentarians drafted a framework document to guide West African legislatures on making effective contributions to national responses. On the other side of the continent, in mid-2001, 80 members of parliament in the United Republic of Tanzania created the Tanzanian Parliamentarians AIDS Coalition, to advocate inside and outside of parliament.

Political leadership at a more local level is also important. In Belarus, the National HIV Council has counterparts at the regional and municipal levels. Each is assured political clout by the fact that a deputy head of local government chairs the local councils. Already, some of these decentralized HIV councils are helping place HIV on local agendas.

Mobilizing all sectors of society

An important role for governments is to clear the way so all sectors of society can contribute to the response. Countries that have employed multisectoral approaches have seen their national response bolstered by the involvement of religious, cultural and community groups or associations, employers, trade unions and nongovernmental organizations.

In Africa, especially, it has become commonplace to include multiple ministries, as well as representatives of civil society and other development partners in high-level political coordination structures. Togo provided a recent example when its president set up and chaired a National AIDS Council that now includes representatives from several government ministries, civil society and the private sector. This kind of example is being repeated in other countries. In the Caribbean, for example, the Government of St Kitts and Nevis recently expanded its National AIDS Advisory Committee to include trade unions, nongovernmental organizations, organizations of persons living with HIV/AIDS, religious organizations, and the private sector.

The fact that more and more national AIDS councils, commissions or similar bodies are led by presidents, prime ministers and vice-presidents reflects the threat posed by AIDS to national development. This high-level leadership not only demonstrates political commitment, but also increases the pressure on non-health ministries to develop activities to fight AIDS within their normal programmes.

Caution is called for, though. Political mobilization and policy-making bodies must be managed carefully to avoid creating confusion between existing institutions that already implement AIDS-related activities.

Table 3

Number of National AIDS Councils, Commissions, or similar bodies chaired by presidents, prime ministers or their deputies/vices			
Africa (13)	Asia (5)	Eastern Europe & Central Asia (5)	Caribbean (4)
Botswana, Burkina Faso, Burundi, Central African Republic, Côte d'Ivoire, Ethiopia, Ghana, Mozambique, Nigeria, Senegal, South Africa, Swaziland, Togo	China, Mongolia, Nepal, Thailand, Viet Nam	Belarus, Kazakhstan, Kyrgyzstan, Tajikistan, Ukraine	Barbados, Dominican Republic, Haïti*, St Kitts and Nevis
* In Haïti, the body is chaired by the First Lady.			

Ministries of Health, for example, have traditionally taken the lead on AIDS programming, often through National AIDS Control Programmes. One way to avoid possible conflicts is by setting clear responsibilities for coordination, advocacy and policy-making in a manner that does not undermine the mandate of health ministries or of other existing structures. In Kenya, for example, the National AIDS Control Council takes the lead on coordination and evaluation of all activities against AIDS, while the Ministry of Health still manages the mainly health-related interventions. Large-scale assistance efforts, such as the World Bank's Multi-Country AIDS Program for Africa, have provided funds to both the National AIDS Control Council (to support coordination work and to channel funds to non-health ministries and nongovernmental actors) as well as to the Ministry of Health.

Within such coordinated frameworks, more and more countries are showing how individual ministries can integrate AIDS into their existing mandates, often in coordination with other ministries and agencies. In Sri Lanka, for example, the Ministry of Labour, the

Health Education Bureau, and the Ministry of Women's Affairs have taken on the issue of sexually transmitted infections and HIV/AIDS in free-trade zones. As a result of these zones' attraction for both national and international migrant workers and changing income structures, the risk of HIV/AIDS can be increased in these zones and surrounding areas. The ministries cooperate with nongovernmental organizations to provide prevention services for workers in the zones. And, in the transport sector, the Ministries of Railroads in China and Mongolia have launched programmes for young migrant workers travelling in their respective countries.

Since AIDS is an issue that concerns society as a whole, responses to the epidemic must be linked to national development issues (such as labour and trade) and to development instruments such as Poverty-Reduction Strategy Papers. In Africa, for example, 10 countries have budgeted about 5% of their debt savings for AIDS activities under the highly indebted poor countries (HIPC) debt-relief programme (see 'Meeting the need' chapter).

Meanwhile, Thailand's Eighth National Economic and Social Development Plan,

which factors AIDS into the nation's overall development strategy, treats AIDS as inseparable from other development problems. This reflects the Plan's focus on holistic development and long-term capacity building—an approach that has been adopted in all AIDS-related planning during this period.

Building up, and on, civil society

Multisectoral approaches have another important virtue: they are key to building capacity within civil society and enabling people and groups to be active participants in, rather than passive targets of, programming. Civil society organizations play important roles in advocacy,

participating in policy and programming design and implementation, and in the provision of services, especially at the community level.

For example, a great deal of Brazil's success in HIV prevention is due to the country's 600-plus nongovernmental and community organizations. For the past decade or more, these organizations have established needle-exchange schemes, distributed condoms, managed support groups and provided counselling. They have also kept HIV/AIDS in the public spotlight, providing essential political pressure when needed. In 1999, when the Health Ministry faced cuts to its budget for AIDS, tuberculosis and other diseases, these groups

The contribution of faith-based organizations

Faith-based organizations are playing an important role in responding to HIV/AIDS. In Africa, church-supported hospitals and clinics were among the first to care for people who fell ill with AIDS. Faith-based organizations have a key role to play, too, in advocacy and prevention.

In South-East Asia, Buddhist monks and nuns in Cambodia, Thailand and Viet Nam provide care and support to people with HIV/AIDS, while also engaging in prevention work. The Catholic organization Caritas International has for many years conducted theological reflections on HIV/AIDS, while many national Caritas organizations provide care and support for people living with HIV/AIDS and for orphans. In Africa, for example, USAID provides grants to support the strategic planning and programme activities of a variety of religious networks, including the All-Africa Conference of Churches, the Organization of African Instituted Churches, the Islamic Medical Association of Uganda, the Church of the Province of Southern Africa (Anglican), and the Uganda Interfaith Alliance. Elsewhere, the Latin American Episcopal Conference works with UNICEF's regional office to arrange HIV/AIDS workshops and training courses for pastoral workers in parishes across the region.

Faith-based organizations have enormous influence over the cultural norms that guide individual and community behaviour and that affect how information about AIDS is interpreted. Some have objections to the use and promotion of condoms, preferring to stress the teaching of faithfulness and abstinence as prevention measures. Such teaching can be effective in helping change behaviour in positive ways, if people also gain the ability to adhere to it in their daily lives. Other faith-based groups, such as the Islamic community in Uganda, have publicly indicated that education on responsible use of condoms was acceptable. Similarly, the Ecumenical Advocacy Alliance's recent action plan cites sexual education as a key tool for HIV prevention, and stresses that people need factual knowledge on sexual anatomy, physiology and psychology in order to be able to live safely in abstinence or fidelity.

mobilized. Their street protests and other activities were widely covered in the press, and received strong support from some parliamentarians. In the end, the funding was restored. A strong civil society flourishes in an environment in which the State allows for such nongovernmental organization participation. In an activist mode, civil society organizations must be empowered by law and daily practice to organize, publish and collect information, while having legal recourse to the courts and, if necessary, the option to demonstrate. As active participants in policy and programming design and implementation, they must be at the table, right from the beginning.

The recent development of the United Republic of Tanzania's national AIDS policy, for example, was based on widespread consultation with all ministries and a range of civil society organizations. One issue that benefited from the participation of civil society (in this case, including private business) was the response in the workplace to HIV/AIDS. Representatives of the Ministry of Labour, and employers' and workers' organizations worked together to create policies based on the ILO Code of Practice.

Important recent financial initiatives have also incorporated the role of civil society into design and implementation. The World Bank's Multi-Country AIDS Program for Africa explicitly aims to use nongovernmental organizations as implementing partners

for approximately 50% of the funding provided. The recently-established Global Fund to Fight AIDS, Tuberculosis and Malaria requires country proposals to pass through 'Country Coordination Mechanisms', which should involve civil society.

The principle of the Greater Involvement of People Living with HIV/AIDS (GIPA) remains a cornerstone of multisectoral responses. Historically, in countries such as Australia, Brazil, Côte d'Ivoire, France, Norway, Thailand, Uganda and the United Kingdom, organizations of persons living with HIV/AIDS have helped draft national plans and tailor them for grass-roots conditions. This is occurring in more and more countries, with heartening results. In Cambodia, for example, the establishment of a national network of persons living with HIV/AIDS in 2001 reflects a positive social environment that is very different from that of even two years ago. The legitimacy of the network was confirmed by the government's recent decision to include representatives of persons living with HIV/AIDS in Cambodia's Country Coordination Mechanism. On a policy level, this is reflected in the new 'National strategic framework for a comprehensive and multisectoral response to HIV/AIDS, 2001–2005', which explicitly endorses GIPA as an overriding principle of the national response. Many examples also come from Africa, where GIPA has been strongly promoted (see 'Prevention' chapter).

Institutional structures: the building blocks of the response

Diverse institutional structures and arrangements need to be in place to turn political commitment and multisectoral participation

into effective programming. National Strategic Plans are the main tools for prioritizing and budgeting a country's HIV/AIDS activi-

ties, since they provide the operational framework for investing new and existing financial resources. They also serve as a map for implementing structures, and highlight where human and institutional capacity must be strengthened.

Strategic planning and implementation

In January 2001, UNAIDS carried out an assessment of country readiness in order to determine how to apply increased levels of funding to HIV/AIDS programmes. The 114 countries assessed were drawn from all regions. 'Readiness' was assessed according to the status of five core components:

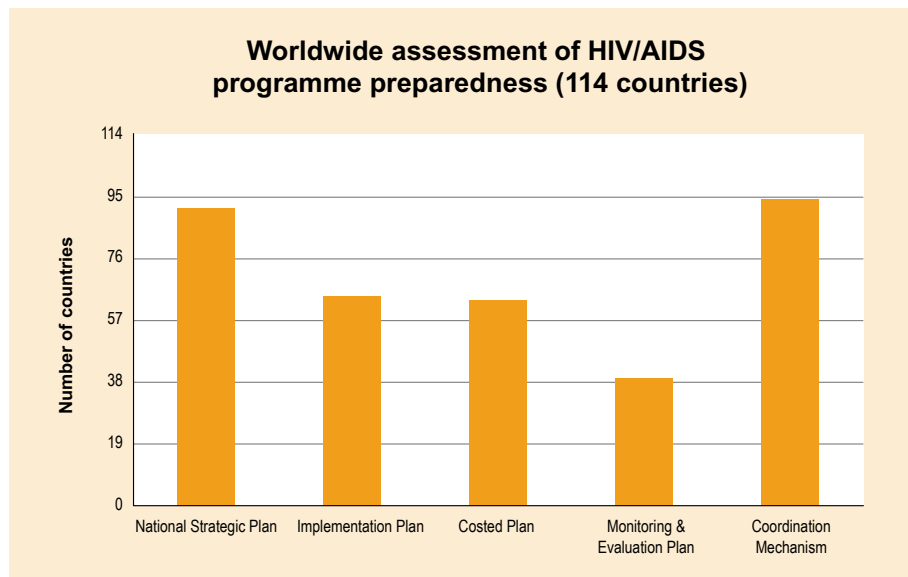
- a national strategic AIDS plan;
- capacity to operationalize the plan;
- detailed costing of the strategic plan;
- a monitoring and evaluation strategy; and

- mechanisms that can achieve coordination among governments, nongovernmental organizations, the United Nations system and bilateral donors.

The results of the assessment are summarized in Figure 44. The relatively high number of national strategic plans and coordination mechanisms reflects the progress that has been made in terms of political leadership and the commitment of governments to mobilize a response to AIDS. Approximately 100 countries were able to draft proposals for the Global Fund within about six weeks, largely thanks to the existence of strategic plans and coordination committees that could be easily adapted to the Global Fund's requirements.

In Africa, there remain only a handful of countries with no AIDS response. But, in many cases, plans are still in their early stages, and costing and monitoring elements are still being elaborated. In Asia, planning is generally well advanced; in the few excep-

Figure 44



Source: Joint WHO/UNAIDS presentation, 27 January 2002, Geneva

tions, the lack of preparedness may reflect a relatively low priority assigned to AIDS activities because HIV prevalence is still low. European responses to HIV vary. In some cases, programmes are only now gearing up to deal with recent steep increases in HIV incidence. AIDS responses in the Americas are, in many cases, long-standing and comprehensive, although there are a few countries that still lag behind.

Overall, fewer countries had costed plans, and fewer still had monitoring and evaluation systems set up to help manage and adjust the implementation of activities. These findings highlight the need to focus on capacity-building for the management of programmes around the world.

While the review looked at preparedness, the results should not imply that resources must only go to the best-prepared countries: in some cases, the need is greatest precisely because the countries are ill-prepared to meet the challenges of AIDS.

National coordination

A national response based on strategic planning and multisectoral approaches is not a magic solution to all possible challenges. In fact, it could even trigger some new complications such as ‘turf’ conflicts, unclear divisions of responsibility, competition over budget allocations, and inconsistencies between ministries and sectors. It is therefore essential to have in place solid national structures that coordinate high-level decision-making with the operational arms.

Over the past two years, several countries have made substantial progress in creating institutional arrangements to better coordinate and manage their national responses.

Each has gone about this differently. Côte d’Ivoire has created a HIV/AIDS Ministry, while Cambodia has a National Authority, which is an inter-ministerial body comprised of 15 ministries, the Cambodian Red Cross and provincial governments. Brazil’s National Coordination Unit (located within the Ministry of Health) has been the model for some countries, while others have followed the approach established in the early 1990s by Thailand, appointing councils or commissions in the office of the president or prime minister. In a number of African countries, presidents, prime ministers, or their deputies chair national councils. Some central Asian countries have adopted the same model. Kazakhstan, for example, has both Central and Regional Cross-sectoral Committees, chaired by the Deputy Prime Minister and Deputy Governors respectively. Whatever type of body is created, it requires technical expertise and sustained resources, and it should be set up with clear mandates, lines of accountability and appropriate staff.

Ethiopia’s experience illustrates how coordinating arrangements can spread from the national to the local levels. The government has a multisectoral National HIV/AIDS Council chaired by the President, and composed of members from government, sector ministries, religious organizations, nongovernmental organizations, the private sector and people living with HIV/AIDS. Supporting the Council is a Secretariat within the Prime Minister’s office, along with advisory and review boards, and various subcommittees. Similar structures exist in the regions: at the *Woreda* (district) level, and at the *Kebele* (local) level. The Secretariats at national and regional levels coordinate and facilitate the day-to-day

Four promising national responses

Strong national responses are evident in each region of the world, as the following examples show, each in its own way. Although the epidemic is at a different stage in each country and socioeconomic conditions differ, similarities are apparent. They include a high level of political commitment, good coordination mechanisms, thorough planning, and successful resource mobilization.

- In recent years, Barbados has responded vigorously to its rapidly growing epidemic. In September 2000, coordination of the National AIDS Programme was placed in the Prime Minister's office. While the country is financing most of its HIV/AIDS programming with its own funds, its strong planning and implementation arrangements have also earned it a US\$15.5 million World Bank loan for HIV/AIDS.
- Botswana faces one of the most severe epidemics in the world. Under the leadership of its President, who chairs the National AIDS Council, Botswana is one of the first African countries to adopt second-generation planning by moving from a primarily health-system-oriented stance to a broad-based multisectoral one. Despite the high cost of the response, the government is financing a large part itself.
- Cambodia is still rebuilding after decades of conflict, and the country faces huge deficits in infrastructure and resources. Yet it has made progress in its fight against AIDS. Over the past two years, it has reduced adult prevalence rates (see 'Global overview' chapter) and has also shown resolve on the policy front, with a new human rights-based AIDS law due to be implemented in 2002.
- Ukraine is dealing with a rapidly expanding epidemic at the same time as it attempts to manage its transition to a market economy. With strong leadership from the President, and the increasing involvement of civil society, however, a detailed response is being implemented. Significant resources are being focussed on prevention among young people and vulnerable populations, and there are strong sectoral responses from various ministries and the defence and penitentiary services.

implementation of the HIV/AIDS programme, while a Project Coordination Unit is located within the National HIV/AIDS Council. Resources normally flow from this unit to the regions and the *Woredas*, but an Emergency HIV/AIDS Fund provides flexibility. It can channel money directly to the regions and *Woredas*, when needed.

Another useful coordinating mechanism is the United Nations Theme Group on HIV/AIDS, which strives to improve coherence among stakeholders involved in government-led responses. Theme Groups are the primary channel and vehicle for the United

Nations system's collective support to, and collaboration with, countries. Since being set up in a few countries in 1996, many Theme Groups have evolved from forums for information-sharing into vehicles for mobilizing political commitment, or for facilitating partnerships between national and international partners. In Central Asia and Eastern Europe, for example, 26 Theme Groups have been created, including those in Kosovo, Montenegro and Serbia. They have proved particularly useful in building bridges for multi-partner initiatives such as the region's Inter-Agency Group on Young People's Health, Development and Protection.

Similarly, the coordinating councils of non-governmental organizations have helped avoid duplication, prioritize action, and add greater weight to advocacy work. Uruguay now has a National AIDS Nongovernmental Organizations Forum that can provide greater coherence to nongovernmental organization activities around the country. The Forum will maintain close ties with the Ministry of Health's National Coordination Unit. Similar structures are being formed in Argentina and Paraguay.

Decentralization and local responses

In addition to developing coordination mechanisms, countries need efficient mechanisms for decentralizing services. This is to ensure that national responses are effective throughout each country, in both urban and rural areas.

District-level responses have emerged as prominent decentralization tools. In countries where the district is the administrative unit closest to individual communities, it can serve as a bridge between community efforts and national strategic planning, and as a site for multisectoral planning.

Mali, for example, approved a 2000–2001 action plan to strengthen district capacities. Its strategy is to build local partnerships with service providers, which will result in the One NGO. One District Initiative on HIV/AIDS (*'Un cercle, une ONG', 'cercle'* being the Malian term for 'district'). By 2006, the Initiative aims to cover the country's 702 local government units (communes), each of which will have an action plan and the necessary local partnerships to implement it.

Zimbabwe has adopted an innovative approach for decentralizing funding, by linking its AIDS

levy with its District AIDS Plan process. The levy was created in 1999 to supplement funding available to the Ministry of Health and Child Welfare for HIV/AIDS and other activities. Under the levy, individuals and companies pay 3% of income and corporate taxes to a National AIDS Trust fund that is administered by the National AIDS Council. The National AIDS Council at first disbursed the funds to organizations working in HIV/AIDS, but discovered that this mainly benefited well-established organizations. In 2001, a process was established to create community-based Action Plans in each of the country's 55 districts, along with AIDS Action Committees at district, ward and village levels. Disbursements would be made into community bank accounts, and be based on community priorities detailed in the planning process. By the end of that year, each district level had initially received about US\$90 000 (roughly equivalent to 5 million Zimbabwe dollars at the time) from the National AIDS Council.

The United Republic of Tanzania, whose district responses have been promoted for several years, offers an example of how such programmes can be refined and enhanced. In June 2001, the Tanzania AIDS Commission agreed to conduct a district capacity assessment that would aid in the development of planning, coordination and funding mechanisms at the district and community levels. The study recommended, among others, greater use of local leaders to fight AIDS, improved funding mechanisms to ensure that funds reach villages and communities, and more communications activities geared towards villages and rural communities. As a result of the study, the guidelines for District AIDS Action Committees will be reformulated.

Capacity development

Developing the capacity to implement and manage the necessary programmes is crucial. In some places, a generalized lack of capacity hampers development activities, particularly in societies emerging from conflict or profound political change.

Almost everywhere, though, some capacity exists in most areas of prevention, treatment, care and impact mitigation. And that capacity can be enhanced. The greatest needs are in sub-Saharan Africa. A variety of initiatives exist to meet these needs, including programmes by UNDP and the World Bank to improve public administration on a wide scale, and the efforts of WHO to improve health systems'

performance. Other initiatives deal directly with capacity to manage AIDS programming, such as the Regional AIDS Training Network of Eastern and Southern Africa. The Network links 17 training institutions across the region to provide a range of courses for middle-level managers, supervisors and trainers from public institutions, nongovernmental organizations, and the private sector. It also provides training for teachers, religious leaders and officials in government ministries, along with managers of factories, commercial firms and decision-makers in the private sector.

Training and skill-building are key components of capacity development. But boosting the human capacity needed to get the job

District response in Burkina Faso: teething problems or flawed design?

The experience of Gaoua District, in Burkina Faso's Poni Province, reveals both the potential and the pitfalls of HIV/AIDS district initiatives. Facilitated by UNAIDS and with initial funding from the German aid agency GTZ, the Gaoua Multisectoral Plan (GMP) began in 1997 with a situation analysis that was based on consultation with a wide range of groups. The resulting two-year plan for AIDS prevention and care was accepted by a group of donors in 1999, including several UNAIDS Cosponsors. The plan covered not only 'health' issues but also larger questions such as the migratory patterns that help spread the virus in the district. The plan received widespread support among the local population.

By 2000, however, the plan was in trouble. Less than a year's activities were eventually funded, and medicines and test kits never arrived, undermining much of the planned patient care and counselling. Reasons included problems with the national purchasing systems, complicated procurement and disbursement procedures, ownership conflicts between the national and local levels, the burden of meeting so many agencies' reporting requirements, and the constant rotation of government officials and administrators. One outcome was considerable resentment towards donors and national authorities.

A new, expanded initiative, called the '*Projet Pilote*', has now superseded the initial plan, with funding from a single donor—the World Bank. The new initiative has been extended to over 500 villages throughout Poni Province. It features new accounting procedures that will provide each village and the eight sectors of Gaoua with a bank account to pay for their own, locally-designed care and prevention projects. The success of this new initiative, it seems, will depend on whether effective local ownership and control of sustainable resources are achieved.

done requires people with the necessary skills and expertise, along with environments conducive to maintaining and building capacity. The UNAIDS Secretariat, in partnership with the US Agency for International Development, the World Bank Institute and others, has embarked on a bid to strengthen human capacity in countries worldwide. The aim is to gather technical guidance on how to take 'training' to further levels, and enable individuals and organizations to recruit, develop and keep skilled leadership for HIV/AIDS-related action.

In Eastern Europe and Central Asia, many countries inherited an extensive social and health infrastructure. But that capacity is not always equal to some of the special challenges thrown up by the epidemic, such as HIV prevention among vulnerable groups (e.g., men who have sex with men, sex workers, and injecting drug users). To a large extent, national programmes are not yet able to fully monitor HIV among these groups, and they lack the personnel with the skills to implement effective interventions. Considerable government investment will be required for relevant training.

Small-scale projects can build the evidence required for advocacy with governments and

provide a basis for expanding activities aimed at preventing HIV infection among injecting drug users. Some of the injecting-drug-user projects funded by the Open Society Institute in the Russian Federation are good examples of this. In the city of Kazan, in the Russian Federation, one such project has successfully used the so-called 'snowball' method. (Like a rolling snowball, outreach workers start small, initially disseminating information and syringes to a small number of injecting drug users; once trust has been established, these injecting drug users help the outreach workers find and work with others.) At the end of 2001, the project's coverage had extended to 38% of the estimated local injecting-drug-user population after only 18 months of operation.

South-to-South technical cooperation is also increasing. As part of a UNAIDS strategy focused on national uniformed services, several 'peer' countries in Africa will serve as reference points in each subregion: Namibia among Southern African Development Community member countries, Senegal for Francophone West Africa, and Uganda for Anglophone East Africa. It is hoped that many other countries, particularly those affected by conflicts, will also gain from the peer country initiative.

Mobilizing resources... and putting them to work

Setting priorities and budgets

Budget allocation is one of the clearest expressions of a government's priorities (see 'Meeting the need' chapter). Recently, the Government of Pakistan demonstrated the depth of its

commitment by making HIV/AIDS a protected expenditure within the national Social Action Programme. Other countries (most recently, Burundi, Morocco and Peru) have shown their commitment in a different way, by abolishing taxes on imported antiretroviral

drugs, even though the forgone tax revenue could turn out to be substantial as access to drugs improves and more people are able to afford such treatment.

Effective and transparent use of financial resources

While great strides have been made in strategic planning, systems to manage increased resources remain weak in most areas of prevention, treatment, care and impact mitigation. There are still too many blockages between resource availability at global level and resource needs at the local, village and neighbourhood level. Addressing these weaknesses—‘unblocking the pipeline’—is crucial.

An important positive development has been the more effective and transparent use of resources. To date, 12 African countries have established the management capacity to deal with big increases in funding through the World Bank’s Multi-Country AIDS Program for Africa (MAP), and another 15 are establishing the fiduciary infrastructure required. The MAP places special emphasis on building local-level capacity, and a large share of its resources (as high as 50%) is earmarked for community organizations so they can carry out activities of their own design.

In conclusion

Depending on the perspective, an overview of national responses can prompt despair or hope. For those living with HIV/AIDS, most would bear witness to there being too little too late, while hoping that more could be done urgently. However, in historical terms,

Resource mobilization through AIDS round tables

Special ‘AIDS round tables’ (which showcase HIV/AIDS strategies in order to attract greater donor funding) can help unlock more resources, as countries such as Burkina Faso, Burundi, Ethiopia, Ghana, Lesotho, Malawi, Mozambique, Swaziland and Zambia have shown.

In June 2001, for example, Burkina Faso organized a round table that featured its five-year multisectoral strategic framework (2001–2006). The framework was supplemented with a set of one-year national action plans, along with an activity-based budget. Donors reacted positively, pledging US\$113 million to the plan—a reflection of the value donors place on lucid and straightforward strategies. Bilateral donors (led by France, Germany and the Netherlands) pledged more than US\$37 million. Burkina Faso itself contributed US\$3.5 million from its national budget, as well as adding a further US\$6.5 million from debt savings and a US\$22 million loan from the World Bank’s Multi-Country HIV/AIDS Program for Africa. UN agencies contributed US\$7 million more in grants, while private sector companies pledged almost US\$10 million.

AIDS is bringing forth national and global responses that are little short of revolutionary.

Only a decade ago, the challenge of engaging the attention of political leaders in the fight against AIDS appeared too great. Today, one sees examples of Heads of State worldwide

Management of funding: Nigeria gears up

In order to manage resources for AIDS, such as a major loan/credit provided by the World Bank, Nigeria has forged ahead in setting up financial supervision systems that fit its particular conditions. The country has a federal system of government, under which important powers and responsibilities for health services are decentralized to the State and local government levels.

The federal National Action Committee has been entrusted with setting standards acceptable to donor agencies in key areas, such as the creation of financial accounting systems, procurement of goods and services, and monitoring and evaluation. While the Committee does not interfere with the day-to-day running of activities by State-level agencies, the latter periodically furnish it with lists of approved community projects and progress reports. The Committee is also responsible for central procurement of goods and services required to implement the National Strategic Plan. It does so in consultation with the State-level agencies. Monitoring and evaluation of outputs (e.g., what was done, how many people benefited, etc.) will be a joint process, with data assembled by the individual States and synthesized by the Committee.

displaying unmistakable personal commitment. The barriers to involving sectors outside health are steadily being removed. And there is increasingly sophisticated understanding of the suffering caused by the epidemic and of the connections between HIV/AIDS and the achievement of national development goals. More and more, political leaders are personally overseeing the coordination of national activities, bolstering human and financial resources, and supporting effective decentralization as a means of expanding activities.

Demands for efforts to succeed are increasing and successful results are multiplying. Traditional institutional models are being revamped or successively replaced, involving radically new ways of doing business. The collaboration between ministries, people living with HIV/AIDS, and the nongovernmental and private sectors in jointly defining and planning responses to the problem is unprec-

edented. The increased attention paid to the effective and transparent use of resources also indicates the seriousness with which AIDS is being addressed. Finally, lessons learned in programme development and in identifying, harnessing and enhancing existing capacity in local contexts are being put into practice.

In addition to successes in curbing the epidemic and alleviating its impact, there have been additional and unexpected benefits. At a national level, AIDS has increased opportunities for dialogue between governments and civil society. In the fight against AIDS, common ground is increasingly being found among diverse constituencies, and across cultures, classes and religions. AIDS highlights the realities endured by vulnerable and disadvantaged people, as well as the need for support for basic human rights and action to overcome socioeconomic hardship. Where governments show vision and commitment in tackling AIDS, effective programmes are not

Utilizing the greatest resource

People living with HIV/AIDS are probably the greatest resource in the global response to the epidemic, as has been proven repeatedly in countries where such individuals/groups have had the political space and resources to get involved. On every continent and in most countries, networks of people living with HIV have formed. Many of these groups are the result of individuals coming together to share their common experiences and give mutual support, but many have evolved into service providers. Regional and global networks of people living with HIV, and of HIV-positive women, are significant players in policy formation. In addition, there are many initiatives that are designed to strengthen the contributions of people living with HIV. While the potential of many groups of people living with HIV/AIDS remains untapped in many countries, several initiatives are yielding results.

In September 2000, the Centre for African Family Studies and Positive Action (the HIV community programme of GlaxoSmithKline) launched an initiative to develop and organize community-based groups and networks of persons living with HIV/AIDS. It aimed to strengthen networks in Africa so they could actively participate in national and international HIV/AIDS policy discussions. The project was started in Ethiopia, Kenya and Togo and is likely to be extended to other countries.

In the first year, multi-level partnerships were created by forming regional advisory and consultative groups and involving local focal persons. Based on a partnership-needs assessment, the Centre developed training curricula and materials. By August 2001, six training modules (in English and French) had been developed for executives, staff and volunteers of community-based groups. The modules cover advocacy, fundraising, networking, communications, management and leadership.

The technical assistance provided to groups of persons living with HIV/AIDS is enabling them to develop and implement action plans that strengthen their respective organizations. In Ethiopia and Togo, the first step was to establish national networks, which the Centre did by working with National AIDS Programmes, ministries of health and UNAIDS Country Missions. In Kenya, the National Network of People Living with HIV/AIDS in Kenya benefited from the Centre's institutional analysis that strengthened and expanded the network.

the only outcome. Leadership is rewarded: effective responses to AIDS have received political support both within nations and across regions.

At the global level, a unique set of actors has been mobilized (not least by people living

with HIV) forging links within and across nations to reshape global policies. At both the national and global levels, all actors are now backed by growing momentum for change. Expectations have been set for bold and ambitious steps to strengthen the response. 