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Universal access: Moving beyond the rhetoric
Progress on universal access to HIV prevention, treatment, care and support

Report from the community sector

SUMMARY

This report summarizes the key findings of comprehensive community sector analysis led by ICASO's partners in 15 countries and 4 regions. The studies assess the status of universal access to HIV prevention, treatment, care and support in 2010 – the deadline agreed by the world's governments for universal access. They particularly focus on issues of HIV prevention, key populations and human rights. Based on the evidence provided, this report 'takes stock' - identifying successes, gaps and challenges. It explicitly aims to inform the critical discussions, debates and decisions of the Comprehensive AIDS Review – by advocating for why universal access still matters and what steps are needed to make it a reality.

The ICASO research confirms that important progress is being made. Despite some limitations, it is now the 'norm' for community sectors to be involved in universal access processes and for national strategies to be increasingly comprehensive, including articulating a commitment to human rights. Also, some key interventions – such as the availability of antiretroviral therapy – have been scaled up, for example, through decentralization strategies involving the community sector.

However, ICASO's partners also report many challenges. These are particularly seen in relation to the lack of progress in: HIV prevention for key populations (including in concentrated epidemics); programmes to address stigma and discrimination and protect human rights, especially of key populations; and interventions to address gender inequities, especially for women from key populations. Some of these challenges remain the same as documented by ICASO within the original target setting for universal access (2006/7) and interim review (2008). Meanwhile, new trends are also emerging, such as growing concern about political de-prioritizing of HIV and lack of funding commitments and predictability, in addition to access to domestic and international resources.

This report highlights how, by 2010, despite impressive efforts in some contexts, none of the countries addressed by the ICASO research had met all of their targets for universal access and in fact, most remained appallingly 'off-track'.

BACKGROUND

1. The International Council of AIDS Service Organizations (ICASO) coordinated a global community sector[1] initiative to assess the status of HIV prevention, treatment, care and support in 2010 – the deadline agreed by the world's governments for universal access.

2. While addressing universal access as a whole, the project focused on **HIV prevention** and **key populations**[2] – issues identified as critical gaps and challenges in a preliminary analysis carried out by ICASO. In addition, human rights issues, particularly stigma and discrimination were explored. This Executive Summary outlines the key findings, with a fuller report available.

3. The initiative used a combination of community led methods to gather and analyze information, through questionnaires, desk reviews, one-to-one interviews, and focus group discussions with relevant stakeholders, as well as national meetings to confirm key findings. Each ICASO partner produced national and regional reports summarizing the findings of their research and making recommendations for action. They also developed and implemented a national Universal Access advocacy plan.

4. The ICASO project was implemented by 4 regional partners: African Council of AIDS Service Organizations (AfriCASO); Asia and the Pacific Council of AIDS Service Organizations (APCASO); Eurasian Harm Reduction Network (EHRN) for Eastern Europe and Central Asia (EECA); and Latin American and Caribbean Council of AIDS Service Organizations (LACCASO). In turn, these organizations supported partners in 15 countries [Figure 1]. Overall, including all of those covered by the regional analysis, the project addressed more than 38 countries – representing diverse contexts, including in terms of HIV epidemics, national responses and community sectors.[3]

Figure 1: ICASO project regions, countries and partners

Region	Partners		
Africa	**Regional partner**	**African Council of AIDS Service Organizations (AfriCASO)**	
	Country partners	**Ghana**	Ghana HIV and AIDS Network (GHANET)
		Kenya	Kenya AIDS NGOs Consortium (KANCO)
		Morocco	Association de lutte contre le SIDA (ALCS)
		Senegal	Réseau National des PVVIH (RNP+)
		Tanzania	Tanzania AIDS Forum (TAF)
	Other countries in regional report	Cameroon, Cote D'Ivoire, Ethiopia, Mali and Mauritania	
Asia	**Regional partner**	**Asia and Pacific Council of AIDS Service Organizations (APCASO)**	
	Country partners	**China**	Yunnan Daytop Drug Abuse Treatment and Rehabilitation Centre
		India	Indian Network of People Living with HIV/AIDS (INP+)
		Indonesia	Our Voice
		Vietnam	Centre for Supporting Community Development

[1] Community sector' is defined as individuals, groups or associations which are separate from the government and the private sector and which undertake actions and present views in support of community members living with or affected by HIV. *Coordinating with Communities: Guidelines on the Involvement of the Community Sector in the Coordination of National AIDS Responses,* ICASO, AfriCASO and the Alliance, May 2007.

[2] 'Key populations' are defined as groups of people who are key to the dynamics of, and responses to, the HIV epidemic. Depending on the context, these include: people living with HIV; orphans and vulnerable children; women and girls; young people; sex workers; people who use drugs; men who have sex with men; transgender people; migrants; refugees; and prisoners.

[3] *Focus countries: Ghana, Kenya, Morocco, Senegal, Tanzania, China, India, Indonesia, Vietnam, Kazakhstan, Romania, Ukraine, Bolivia, Colombia, Peru. Additional countries: Cameroon, Cote D'Ivoire, Ethiopia, Mali, Mauritania, Bangladesh, Cambodia, Laos, Myanmar, Nepal, Pakistan, Sri Lanka, Albania, Belarus, Georgia, Republic of Macedonia, Argentina, Brazil, Guatemala, Mexico, Nicaragua, Panama, Uruguay.*

			Initiatives (SCDI)
	Other countries in regional report	Bangladesh, Cambodia, Laos, Myanmar, Nepal, Pakistan and Sri Lanka	
Eastern Europe and Central Asia	**Regional partner**	**Eurasian Harm Reduction Network (EHRN)**	
	Country partners	**Kazakhstan**	Kazakhstan Association of Organizations Working in the Field of HIV/AIDS and Drug Abuse Prevention
		Romania	Sens Pozitiv
		Ukraine	Association of Substitution Treatment Advocates in Ukraine
	Other countries in regional report	Albania, Belarus, Georgia and Republic of Macedonia	
Latin America	**Regional partner**	**Latin American and Caribbean Council of AIDS Service Organizations (LACCASO)**	
	Country partners	**Bolivia**	Instituto para el Desarrollo Humano (IDH)
		Colombia	Liga Colombiana de Lucha contra el Sida
		Peru	Via Libre
	Other countries in regional report	Argentina, Brazil, Guatemala, Mexico, Nicaragua, Panama and Uruguay	

FINDINGS OF THE ICASO COMMUNITY SECTOR REVIEW OF UNIVERSAL ACCESS

ICASO considers universal access to be more than scaling up the response to HIV. It should result in the ability of **all** people to have **equal access** to the quality services and commodities that they need to meet their HIV prevention, treatment, care and support needs.

5. In 2006/7, the **targets set for universal access** varied greatly. Subsequent reviews have brought important additions and improvements, often based on evidence from the community sector. Targets are often of mixed quality and formulation. Where good, they are a 'mobilizing force' for scaled up and accelerated action by stakeholders. However, where they are not inclusive, realistic or appropriately ambitious, or do not reflect national priorities, they risk undermining the legitimacy of universal access. The absence of high quality data on key population sizes and needs is a persistent challenge to setting targets. In some contexts, important gaps remain in targets.

6. **Most counties did not meet most of their targets**, therefore, did not achieve universal access. Some are appallingly behind, with significant shortfalls on critical targets. There are major, common barriers to progress. Many of these relate to wider environmental issues, such as stigma and discrimination and punitive legal environments. They are also persistent, having been identified in ICASO supported community reviews in 2006 and 2008.

Finding 1: Community sector involvement in universal access processes

In many countries, Global Fund-related processes, including Country Coordinating Mechanisms (CCMs), have had 'knock-on' benefits, such as establishing the 'norm' of key population involvement in national planning and programming.

7. Community sector involvement in universal access and related national processes is increasingly seen as 'obligatory' and has improved over time (often due to programmes supported by the Global Fund to Fight AIDS, Tuberculosis and Malaria) complemented greater acceptance by some authorities.

8. In most countries, there was a sense that **community involvement** has improved over time. In 2010, some countries were pleased with the **range of**

representation, such as in: **Sri Lanka**, where the National AIDS Programme (NAP) invited *all* active groups to meetings; and **Cameroon**, where representatives of *all* levels were at consultations. But others were dissatisfied. In **Kazakhstan**, established NGOs were excluded, while, in **Peru**, outreach did not extend to groups of transgender or bisexual people. Also, there were some concerns about the **quality of involvement**. In **Belarus,** the timeframe was realistic (enabling the community sector to hold a caucus to identify priorities) [Case study 1], but, in **China**, it was unfeasible (with insufficient time to complete the preparatory reading for the national consultation, as well as the meeting's format making it difficult to make recommendations).

Case study 1: Using universal access processes to advocate on community issues, Belarus

In Belarus, before the national consultation in 2010, UNAIDS shared a preliminary document on universal access indicators and coverage. Based on this, the Belarusian People Living with HIV Community and Belorussian Association of Non-Profit Organizations Countering HIV/AIDS organized a community caucus. Constituents reviewed national data, developed positions on five indicators and identified strategies to advocate on them. At the consultation, the sector focused on access/adherence to ART and the needs of men who have sex with men and sex workers. Representatives pushed for higher targets for ART, but were countered by the Ministry of Health (citing budget limits). In other cases, they argued for *lower*, more realistic targets. They also called for a more scientific approach to tracking results for key populations.

9. However, significant challenges remain, particularly in relation to the involvement of key populations who are often both stigmatized and criminalized. A large number and range of factors – from punitive legal environments to logistical challenges, negative government attitudes and lack of advocacy capacity – continue to restrict community sector involvement [Figure 2].

Figure 2: Examples of factors affecting community sector involvement in universal access processes, 2010

Helpful factors	Hindering factors
National processes for universal access	
✓ Clear roadmap of the process and roles and responsibilities for different stakeholders. ✓ Transparent procedures, such as for when/how the community sector can give input. ✓ Orientation meetings to 'get up to speed'. ✓ Opportunities for the community sector to dialogue *directly* with the government. ✓ Facilitation from neutral international partners, such as UN agencies. ✓ 'Safe spaces' for people living with HIV and key populations to participate openly.	× Processes being dominated by governments and UN agencies. × Confusion about different national processes (for universal access, UNGASS, NSPs, etc.). × Poor planning, such as when the community sector is invited to meetings at the last minute or given little time to consult constituencies. × Lack of institutional memory among national stakeholders about universal access decisions. × Community representatives being selected by the government rather than the sector itself.
Policy and legal environment	
✓ High level political commitment to a multi-sectoral approach, particularly involving people living with HIV and key populations. ✓ Existing functional national mechanisms that can be utilized for universal access processes, such as CCMs and joint programme reviews. ✓ Relationships of trust between stakeholders, for example, with NGOs able to criticize governments. ✓ Legal environments that protect and promote the human rights of everyone, including people living with HIV and key populations.	× Governments that do not recognize the value of community sector evidence and perspectives. × NSPs that fail to promote multi-sectorality or provide a framework for universal access. × Legal contexts that criminalize and do not protect the rights of people living with HIV and key populations – restricting their participation. × Weak national mechanisms, such as NACs, that fail to routinely involve the community sector (with universal access consultations having to 'start from scratch').
Community sector organizing, resources and capacity	

✓ Existing community sector platforms (to identify priorities, distribute information, etc.). ✓ Elected community representatives in existing decision-making forums (e.g. CCMs) and/or agreed processes to select representatives. ✓ Support from regional NGO networks to share information and connect 'local to global'. ✓ Funding for: on-going Community Systems Strengthening, especially for key populations (e.g. from the Global Fund); and community processes for universal access (e.g. from UNAIDS). ✓ Technical support (especially by the sector itself) to build skills on universal access.	× Lack of community sector knowledge and/or interest in universal access. × Lack of agreed community sector processes (to disseminate information, reach consensus, etc.). × Low interest or availability of resources for advocacy work (as compared to programme implementation). × Dominance of 'the usual suspects' and capital-based community sector groups. × Lack of logistical support for community sector involvement (transport costs, use of local languages, 'NGO-friendly' methods, etc.). × Lack of 'engagement capacity' in communities (e.g. skills in languages, advocacy and M&E).

Viewpoints 1: Involvement of community sector in universal access processes

"In many African countries representatives of the community sector and civil society were significantly involved in the universal access target setting and review processes. But the quality of the involvement needs to be improved in terms of coordination and strategic information sharing." Africa regional report, AfriCASO

"A more cohesive, sustainable and accountable contribution from civil society [to universal access] will require continuing support and appropriate mechanisms from government, stronger commitment from donors and greater efforts from civil society itself." Vietnam report, SCDI

Finding 2: Targets set for universal access

10. In 2006/7, the number of targets[4] set for universal access varied greatly. Subsequent reviews have brought important additions and improvements, often based on evidence from the community sector. ICASO partners reported that some countries used the **2010 review process** to add to or improve their indicators and targets. For example, **Argentina**'s targets were made more relevant to the local context, while **Cameroon** set new targets for coverage of ART for 2015. In **EECA**, at least three countries added indicators on prisoners, while others made their indicators more specific, such as **Romania** – which included one on the percentage of people who use drugs accessing opiate substitution therapy

11. According to respondents, whether set in 2006 or added/modified since, targets for universal access vary significantly in their quality. This includes in relation to whether they are:

- **Inclusive and comprehensive[5]:** In some contexts community groups consider their country's targets to broadly cover the range of interventions and populations needed. But in other countries there are gaps, particularly inadequate attention to the 'drivers' of their country's epidemic, with key populations excluded from indicators. Examples include the absence of targets on specific services for people who use drugs or men who have sex with men (**Mauritania)** and treatment for children (**Morocco**).

- **Realistic and Ambitious[6]:** Some targets set for universal access are simply rhetoric – considering countries' baseline data, resources allocated, and/or political will. In some countries, for example, governments set ambitious targets to scale up rapid HIV testing, but lacked realistic planning and budgeting to cope with the necessary follow up (for example, increased demand for ARV)

[4] UNAIDS provided 7 core and 4 recommended indicators for universal access (with coverage of targeted prevention programmes for key populations to be a core indicator in countries with low and concentrated HIV prevalence).
[5] Including all interventions and groups that are relevant to the epidemic in a particular country.
[6] Aiming to address unmet needs that can be achieved if specific barriers are overcome.

(**Nicaragua**). Some community groups (**Myanmar** and **Uruguay)** described their country's targets as *under*-ambitious, especially concerning national funding of HIV.

12. The absence of high quality data on key population sizes and needs is a persistent challenge to setting targets, especially in concentrated epidemics. It risks progress reviews being little more than guesswork. Some data was described as 'baseless', due to the lack of denominators or use of community evidence. Over-attention to quantitative targets, such as for coverage of ART or HIV testing, risks masking inequities in access (such as for women and key populations) and qualitative issues (such as confidentiality).

Viewpoints 2: Target setting for universal access

"The established targets are not realistic, ambitious and inclusive/ comprehensive. They do not respond to the dynamic or to the needs of the [key] populations." Peru report, Via Libre

"Difficulty in assessing progress is influenced by the absence of targets and performance reports and lack of coordination in the use of the estimated number of key population groups as a denominator." Ukraine report, Association of Substitution Treatment Advocates in Ukraine

Finding 3: Universal access integration into national strategies and budgets for HIV

13. Generally, universal access is now reflected in national strategies on HIV – which are increasingly multi-sectoral, comprehensive and integrate a range of indicators for international commitments.). In some countries, such as **India** [see Case study 2Case study], commitment to universal access for all (including those most marginalized and vulnerable) is seen within the priorities of national strategies.

Case study 2: Emphasising targeted interventions within the national response to HIV, India

In **India**, the National Strategic Plan aims to saturate the coverage of key populations through interventions led by the community sector. Services include condom distribution, testing, STI treatment and harm reduction and opiate substitution therapy for people who use drugs. The national programme has significantly scaled up the number of targeted interventions, from 789 in the previous NSP to over 1,290 by 2009, covering over 1.1 million key populations and representing some 60% of the mapped estimate. In 2009, about 95% of the districts were reached with prevention interventions. There is improved access by key populations to services through an increase in number, geographical distribution and coverage. For 2007-12, 67% of the $2,575 million budget was earmarked for prevention, including among key populations.

14. However, some national responses maintain critical gaps and weaknesses in terms of the strategies, programs and budgets needed to address national priorities and make universal access a reality. Overall, respondents note that countries often still neglect or limit attention to universal access for key populations, especially in terms of the planning and costing of initiatives. These patterns were seen in **Asia** – where epidemics have developed dramatically since 2006 and an analysis of the 2010 UNGASS National Composite Policy Index (NCPI) showed that just 13 of the sample of countries address the needs of *all three* key populations (sex workers, men who have sex with men and people who use drugs). Meanwhile, within the plans of individual countries, there are often gaps for specific priority populations, such as migrants, partners of people who use drugs and military recruits. There are also limited systems linkages, such as between services for HIV and sexual and reproductive health (SRH).

15. The ICASO research highlighted growing concern about whether, even with supportive NSPs, governments have the budgets to make universal access happen. This was fuelled by factors such as the global economic crisis, perceived end to 'AIDS exceptionalism' (and reduced donor interest in HIV) and changing eligibility criteria for the Global Fund. There were concerns about the:

- **Amount of funding for HIV:** Across the regions, it was welcomed that, in recent years - particularly due to resources from the Global Fund – almost all countries' budgets for HIV have increased. Meanwhile, exceptions to the trend were seen in some countries (**Ghana** and **Tanzania**).
- **Eligibility to access funding for HIV:** The community sector expressed even stronger concern about *future* funding for HIV. This was especially the case in regions such as **EECA** – where several countries are completing Global Fund grants and either did not succeed in Round 10 (**Albania**), or, being classified as upper middle-income, will likely not be eligible for future support (**Belarus**, **Kazakhstan, Bosnia Herzegovina** and **Macedonia)**. This will particularly impact on interventions for key populations – which have often been dependent on external funding.
- **Harmonization of funding for HIV:** In many countries, respondents were concerned about on-going lack of coordination among donors and the implications for funding of universal access, creating confusion and over-dominance of donors.
- **Allocation of funding to aspects of HIV:** In some contexts, there are concerns about how budgets for HIV are allocated to different programming areas, especially funding for HIV prevention and, within that, support to key populations. Low and decreasing allocations to prevention were reported in several countries as varied as **Brazil** (with 14% in 2007 reduced to 7% in 2008, despite UNAIDS recommending 30%) and **Ghana** (with 39% in 2005 reduced to 22% in 2008). In **Romania** – where just 4% was allocated to prevention in 2009 – even further reductions in allocations to prevention were predicted with the end of Global Fund resources.
- Low allocations to key populations were seen even in some countries with concentrated epidemics. In **EECA**, these trends were again particularly seen within domestic funding for HIV. While some 50% of international funds are used for prevention, less than 20% of domestic funds are. Over 90% of the region's funding for work with sex workers, people who use drugs and men who have sex with men comes from international sources.

> *"The lack of state support for prevention programs and activities focusing in key populations is especially dangerous for the region as international funding decreases over time."*
> Eastern Europe and Central Asia report, EHRN.

Finding 4: Overall progress toward universal access

16. Countries are making concrete progress towards universal access. There are success stories (such as the increased availability and decentralization of ART) across regions and within individual countries. The community sector has often played a key role [**Figure 3**], increasing the reach, relevance and evidence-base for effective interventions, such as coverage of HIV counseling and testing; coverage of prevention of vertical transmission, provision of harm reduction and opiate substitution therapy for people who use drugs; condom distribution to sex workers; and promotion and protection of the rights of people living with HIV.

17. However, most countries did not meet most of their targets by 2010 and, therefore, did not achieve universal access. Some are appallingly behind, with significant shortfalls on critical targets.

18. The uneven nature of progress is illustrated by extracts from the reports of ICASO's partners, such as:

    - **Tanzania**: *"In some indicators, achievement could not be determined as the data is not available and, in others, no targets were set. In general, none of the indicators were achieved according to the data available. The target of PMTCT was close to achievement and there are indications that this will be the first target to be achieved. Other indicators will require more efforts."*

    - **Romania:** *"From a total of 12 original indicators, for 7 there are no data available, 4 were not achieved and only one was achieved. This proves the low interest in monitoring the progress toward universal access."*

- **Asia and Pacific:** *"No country was on track to meet all their targets by 2010. However, it is highly likely that these targets have played a major role in progressing treatment and prevention coverage levels far beyond what would have been achieved otherwise. A 2010 review of the region has noted that four countries with substantial populations are now on track to achieve MDG 6 by 2015. There have been some remarkable success stories and responses to learn from…….. [but] overall trends in the region on progress toward universal access hide important variations in levels of achievement. While there are success stories, most countries are only partially on track to achieving universal access."*

19. There are major, common barriers to progress. Many of these relate to wider environmental issues, such as stigma and discrimination and punitive legal environments. They are also persistent, having been identified in ICASO supported reviews in 2006 and 2008.

Figure 3: Examples of universal access success stories and contributions made by community sectors

Successes	Examples of contributions made by community sector
Increased access to treatment – *through scaled up provision of ART*	• Decentralizing ART – by implementing or supporting the roll-out of services to a larger number and wider range of facilities. • Gathering evidence of 'what works', especially for reaching key populations. • Increasing treatment literacy, demand and adherence among communities. • Advocating for removal of socio-political barriers to ART services. • Being 'watchdogs', for example of stock-outs of ARVs. • Campaigning for reduced drug prices and action on the indirect costs of treatment.
Reduced risk of HIV transmission – *through large-scale condom distribution (including among sex workers)*	• Implementing outreach to 'hard to reach' communities, including sex workers. • Using creative, rights-based behavior change strategies, such as peer education. • Supporting community-based distribution of condoms. • Advocating for the need for an enabling environment (such as the decriminalization of sex work) to support condom use. • Campaigning for free or low-cost condoms and attention to challenges within supply management systems.
Enhanced enabling environment – *through commitment to human rights in NSPs*	• Advocating for the human rights of people living with HIV and key populations and articulating why they matter within responses to HIV. • Advocating to governments to reflect international commitments to human rights within national strategies on HIV. • Promoting the involvement of people living with HIV and key populations in national decision-making on HIV. • Being 'watchdogs' - monitoring and documenting abuses of human rights. • Providing legal support and 'rights literacy' in communities.

20. From the perspective of the community sector [Case Study 3], the most common and significant barriers to the achievement of universal access can be summarized as:
    1. **Mismatch between national priorities, strategic plans, interventions and budgets,** with a lack of 'know your epidemic' approach and funding not invested in priorities.
    2. **Oppressive legal environments** that deny human rights and criminalize key populations, and/or behaviors and/or the transmission of HIV, and hamper progressive responses to HIV.
    3. **Persistent and widespread stigma and discrimination of people living with HIV and key populations** in communities, health facilities and policy forums.
    4. **Inadequate numbers and skills of health workers,** particularly within government services.
    5. **Weak health systems and infrastructure,** such as to manage supplies of drugs, integrate different aspects of health (SRH, TB, etc.) and reach rural communities.
    6. **Weak capacity, resources and respect for the community sector** to play a full role in all aspects of countries' scale-up towards universal access.
    7. **Lack of implementation of evaluated and proven good practice of 'what works',** especially for key populations, and the will, skills and resources to take them to scale.
    8. **Lack of common understanding among key stakeholders of what universal access is and why it matters, and also belief that it can be achieved.**
    9. **Lack of national leadership and 'drive'** on HIV in general and universal access in particular.

Case study 3: Barriers to the achievement of universal access, 5 African countries

According to community sectors, the barriers to universal access include: In **Cameroon**: poor integration of community sector; poor resource mobilization; lack of decentralized health services; lack of qualified staff; insufficient state budget; weak political will; poor medical infrastructure; poor programme management; stigma and discrimination by health workers; high levels of poverty; unfavourable laws for key populations; and over-dependence on Global Fund resources. In **Ghana**: urban/rural inequities in ART coverage; poor national coordination of procurement; inaccessible diagnostic tests; costs to access services; over-burdened/low capacity health workers; lack of investment in health services; lack of adherence to ART; and stigma and discrimination of people living with HIV and key populations. In **Mali**: insufficient financial and human resources; diminished goodwill; poor governance; lack of commitment from authorities; poor management of funds; weak indicators; lack of observance of protocols; stigma and discrimination of key populations and people living with HIV; lack of information sharing; and slow financing for the purchase of ARVs. In **Mauritania**: low political will; influence of religious sector; lack of resources for prevention; lack of personnel trained on co-infection; lack of referral and follow-up systems; weakness/ inexistence of prevention of vertical transmission programs; lack of a specific strategy for men who have sex with men; low knowledge about STIs; lack of qualified human resources; and inadequate state budget to sustain activities. In **Kenya**: mismatch between location of services/HIV prevalence and prevention expenditure/sources of new infections; inadequate number/capacity of staff; poor information systems; multiple procurement systems; poor coordination of allocation of resources; little harmonization of donors; and lack of alternative financing.

Finding 5: Progress made on universal access to HIV prevention

21. Progress on HIV prevention is 'patchy'. In most cases, prevention risks 'falling off the agenda', especially within the competitive financial environment. Some countries report low, even decreasing, proportions of funding being allocated to prevention, especially from domestic sources.

> *"Even though the HIV epidemic throughout the [Latin American] region is heavily concentrated among men who have sex with men, sex workers and people who inject drugs, only a small fraction of HIV prevention programs focus on these populations"*
> Latin America report, LACCASO.

22. Focused prevention is increasingly recognized in national strategies and some good, community-led practices have been developed. However, these often lack the resources and political support to go to scale and achieve impact on epidemics.

23. In many countries, prevention still fails to reflect the reality of epidemics, such as with resources prioritized for awareness-raising in the general public, rather than priority populations. In particular, greater efforts are needed in HIV prevention for women from key populations.

24. Overall, Global Fund resources have filled critical gaps for HIV prevention with key populations.

25. Many countries have made concerted efforts to increase coverage of **HIV counseling and testing** (universal access core indicator 4). This is evident in **Africa** and **EECA**. In the latter, despite successes, HIV testing does not always reach key populations. In the region as a whole, the proportion of people who use drugs among those undergoing HIV testing *decreased* in 2005-9, while services for sex workers were lacking in countries such as **Georgia** and **Romania** and for prisoners in countries such as **Ukraine**.

26. Respondents emphasized that **prevention of vertical transmission** (universal access core indicator 3) remains a critical intervention not only for babies, but also for women living with HIV. In **EECA**, this area was a success story – with large-scale and routine inclusion in relevant programming. Also, in some **African** countries, there was good progress; however, coverage was disappointing in **Africa** - where 60% of all people living with HIV are women. Similar challenges were seen in other regions, such as **Latin America** (where reach averaged 54% by the end of 2009). In **Tanzania**, prevention of vertical transmission was the universal access target closest to being achieved (with 72% coverage in 2010 against a target of 85%) and the country set an ambitious new target for 2013 (90%).

27. In **Africa** and elsewhere, **female condoms** continued to be largely unavailable and/or inaccessible. Overall, varied progress was reported **on new prevention technologies**. Across the regions, **prevention tools** were restricted by a range of logistical and financial barriers, such as: shortages in supplies of condoms; quality of condoms and other prevention commodities; and cost of water-based lubricant.

28. In some contexts there has been progress on universal access recommended indicator 3 (HIV prevention for key populations) - often due to large-scale resources from the Global Fund. However, the progress has sometimes been modest and/or uneven, as illustrated in **China** - where none of the targets of 90% have been reached and improved coverage for men who have sex with men and sex workers (75% and 74%) far exceeded that for people who use drugs (39%). Similar progress, but also weaknesses, was seen in **India** (with coverage of 78% and 74% of men who have sex with men and people who use drugs, but 53% of sex workers) and in **Ukraine** (with levels of 63% for men who have sex with men, 59% for sex workers, 32% for people who use drugs and just 15% for prisoners).

29. Meanwhile, concern about poor performance was especially high within concentrated epidemics where focused HIV prevention is essential. For example: in **Indonesia,** only 9% of people who use drugs and men who have sex with men were reached; in **Senegal**, there is still a lack of focused interventions for sex workers and men who have sex with men (despite HIV prevalence of 20% and 22% respectively); and, in **Colombia**, respondents described the *"chronic sluggishness"* in targeting key populations.

30. Positive Health, Dignity and Prevention approaches have been implemented in countries such as **Cambodia** (where national guidelines were approved in 2010), **Senegal** (where Global Fund resources enabled reach to over 4,350 people living with HIV) and **Romania** (where initiatives are led by the National Union of People Living with HIV and other NGOs). However, despite increased global recognition of such approaches, relevant activities are still absent from many national responses. This was noted to be broadly the case in **Africa** and **Asia** (where reluctance to adopt the strategy was reported in countries such as **Indonesia**).

31. Across the four regions, it was noted that HIV prevention (including prevention of vertical transmission) can be especially inaccessible for **women from key populations –** who face multiple layers of stigma and inequity related to HIV, gender and their social status.

32. In **EECA** - where support to people who use drugs is critical - progress in this area varied [Figure 4]. In **Kazakhstan**, 60% of such community members were reached with prevention services and harm reduction, including an opiate substitution therapy project funded by the Global Fund and piloted in two regions (with plans to scale up to four). However, in **Ukraine**, where nearly a quarter of people who use drugs are living with HIV, coverage was just 32%, despite scaling up to 108 state and private sector pharmacies providing sterile syringes and other prevention supplies. In the region as a whole, some good progress was reported on developing comprehensive services, with all countries analyzed in the EHRN regional report, including **Romania** now allowing needle exchange and an opiate substitution therapy services.

Figure 4: HIV prevention indicators for people who use drugs, Eastern Europe and Central Asia

Country	HIV prevalence in people who use drugs	Percentage of people who use drugs[7]:			
		Good knowledge of HIV	Safe behavior (using condom in last sexual intercourse)	Safe behavior (using clean equipment in last injection)	Reached by HIV prevention programmes
Albania	n/a	15%	36%	82%	79%
Belarus	14%	58%	59%	87%	64%
Georgia	2%	38%	78%	48%	11%
Kazakhstan	3%	77%	46%	63%	60%
Romania	1%	10%	17%	85%	50%
Ukraine	23%	55%	48%	87%	32%

33. In **Africa**, most countries do not report data on indicators related to drug use. Among the four countries providing relevant information in **Latin America** - a region where about a quarter of the estimated 2 million **people who use drugs** are living with HIV – people who use drugs do not appear to be reached by prevention and have low knowledge about HIV. Meanwhile, mixed progress was reported in **Asia** – another region where focused prevention is critical but funding for harm reduction is just 10% of that needed. Across the regions, the barriers to future scale-up include: service fees for opiate substitution therapy; lack of community support and high drop-out rates; inadequate distribution of needles and lack of links to sexual and reproductive health support. To date, **Indonesia** is the only Asian country to implement all of the nine interventions for harm reduction recommended by UNAIDS and UNODC (although, by 2008, it had still only achieved 29% coverage, despite a target of 80% for 2010). Impressive scale-up has been seen in a number of countries, such as **China**, but, in **Nepal**, just 1% of people who use drugs were enrolled in methadone maintenance therapy and 2% in a buprenorphine substitution treatment. In **Asia** as a whole, funding for harm reduction is just 10% of that needed.

34. In **East, South and South-East Asia,** coverage of HIV prevention programmes for **men who have sex with men** has increased over the past five years, but still averages just 24% - failing to keep pace with escalating prevalence in some countries. In **Indonesia**, despite a 2010 target of 80%, coverage was just 9% by 2008. Meanwhile, in **Africa,** HIV prevalence remained high among men who have sex with men. Here, same sex relations remained largely criminalized and highly controversial, with the needs of men who have sex with men poorly identified and addressed. Some programmes were implemented in countries such as **Cameroon**, where the government recognizes the population as a priority and the provision of HIV and STI prevention is combined with strengthening access to care and treatment and addressing legislative barriers and stigma and discrimination.

35. Some successes are reported, such as with **Cambodia** and **Myanmar** being among only seven countries worldwide reporting over 80% condom use at last sex. Meanwhile, the **Latin American region** - where the highest proportion of HIV infections occurs among men who have sex with men - has seen a general improvement, including with more countries reporting on relevant indicators. In more than half of the countries reporting data, over 50% of those who know their HIV status are reached with prevention programmes and countries such as **Mexico** have increased funding for such initiatives. In **Bolivia**, where prevalence among men who have sex with men is 13%, data indicated that 69% of such community members use condoms.

36. Where data exists, it indicates that **transgender people** often have heightened HIV prevalence and face particularly intense stigma. Yet, the specific needs of this community are often neglected within HIV prevention. In most regions, transgender people are often addressed under the umbrella of men who have sex with men, with little information on the scale and type of their specific needs.

[7] Sourced from partner reports citing national UNGASS reports 2010 and, for Romania, data from UNODC 2010.

37. In **East, South and South East Asia** overall – where an estimated 10 million women sell sex - the average coverage of HIV prevention for **sex workers** was just 40% in 2009. In many countries, while NSPs outlined a range of interventions, these did not always materialize. Examples of challenges include: lack of integration with SRH services; challenges in reaching 'informal' sex workers and lack of user-friendly information materials. Meanwhile, in **EECA**, the proportion of sex workers reached through interventions averaged 66% and appeared to be *decreasing*, despite HIV prevalence *increasing* significantly in the population in some countries (such as doubling in **Belarus** and **Georgia** and tripling in **Ukraine**).

38. Once more, the community sector highlighted the need to address specific *types* of sex workers. For example, in **Asia,** lack of both data and political will has made it especially difficult to reach male and transgender sex workers. Where evidence exists, there are indications of needs being even higher among such groups, such as with HIV prevalence of 20% and 12% among male sex workers in **Indonesia** and **Thailand** (compared to 10% and 5% among females).

39. Where data is available, there are indications of HIV prevalence often being higher among **prisoners** than the general public. In **Asia** and **EECA**, prisoners lack access to free condoms, opiate substitution therapy and needle and syringe exchange programmes. Also, sex among inmates, including males, remains controversial. **Ukraine** – one of the few **EECA** countries to describe the prison situation in its UNGASS report - indicates that, while 13-17% of prisoners are living with HIV, only 15% are reached by HIV prevention. In the last five years, prison-based harm reduction services were initiated in **Georgia** (with the piloting of opiate substitution therapy) and **Romania** (with the piloting of needle exchange and opiate substitution therapy).

40. In contexts such as **Asia** - where an estimated quarter of all people living with HIV (1.27 million) are 15-24 year olds – HIV prevention still tends to use an 'everybody is at risk' approach, rather than one based on evidence. Here, 90% of resources for youth are spent on those at low risk (who represent just 5% of young people living with HIV), while **marginalized young people** lack comprehensive sexuality education and support. Meanwhile, in **Latin America**, sexuality education for young people in schools is often limited and/or under-budgeted, with religious beliefs and structural issues (such as age of consent) continuing to pose barriers.

41. The many and persistent barriers to HIV prevention and other services for key populations include:
    - **Lack of data about population sizes and evidence of needs:** For example, only a third of 35 countries surveyed in **Asia** conduct appropriate HIV surveillance of key populations.
    - **Stigma and discrimination:** Stigma by communities and health workers remains a critical barrier, driving key populations away from life-saving services.
    - **Legal status and criminalization:** Oppressive legal environments restrict access. The many examples of negative practices included: punitive drugs policies (**EECA**); police harassment of sex workers (**Macedonia** and **Serbia**); incarceration of people living with HIV and key populations for 'rehabilitation' (**Asia**); arrest of men who have sex with men (**Senegal**); and criminalization of key populations (**Morocco-** Case study 4)
    - **Lack of government support for interventions:** Lack of political and financial support from governments is a significant limitation to implement interventions for key populations. For example, in **EECA**, 90% of resources for interventions for key populations are provided by

Case study 4: Barriers to HIV prevention for key populations, Morocco

> *"NGOs working with key populations still face difficulties to work safely, especially with MSM and female sex workers. Criminalization of such behaviors remains a real obstacle. The MSM programme has been stopped several times for security reasons to protect outreach workers and the members of the community from police arrests."*
>
> Morocco country report, ALCS

international sources, notably the Global Fund, masking the lack of support from governments and risking longer term commitment.

- **Limited scale of interventions for key populations:** Despite promising examples, many interventions for key populations - including those led by community sectors - struggle to move beyond pilot projects and achieve significant impact on epidemics.
- **Inappropriate prevention messages:** In many contexts, the main HIV prevention messages, particularly by governments, remain inappropriate for key populations, often as well as other groups such as young people.
- **Lack of attention to the multiple needs of key populations:** Policy-makers and service providers lack understanding and strategies for the inter-related vulnerabilities of key populations. For example, studies indicate that: in **Georgia and Azerbaijan**, there are high levels of drug use among men who have sex with men; in **Asia,** many sex workers are also migrants; and in Dar es Salaam, **Tanzania**, many people who use drugs are sex workers.

Finding 6: Progress made on universal access to HIV treatment

42. Increased availability of ARVs[8] (universal access core indicator 1) is an important 'success story' of universal access. This is often credited to 'facilitating factors' such as large-scale funding (particularly from the Global Fund); decreases in ARV costs (through the production of generic drugs); and decentralization of ARV services (with a larger number and range of facilities). Overall, however, the levels of ART coverage still remain low.

Increased access to ARVs must not be seen as a 'done deal'. Despite progress, it is critical to *increase* momentum and resources towards 2015. In particular, the community sector has a critical role to play in initiatives such as Treatment 2.0 that are key to *universal* access

43. Access to treatment can be inequitable. Disparities particularly affect key populations, children, women and those in rural areas. **Levels of coverage** vary significantly (such as from 23% in **Bolivia** to 73% in neighboring **Peru**) and, overall, remain low. In **EECA**, coverage averaged just 19%, with countries such as **Macedonia** and **Ukraine** reporting some of the lowest levels in the world (5% and 16%). Also, the **rate of progress** was disappointing, such as in **Latin America** where access to ARV increased by just 6% in 2009 (compared to a global average of 30%). In **Africa** (home to 23 million people living with HIV) among the 10 countries addressed in the ICASO's research, only three (**Ethiopia, Mali** and **Senegal**) reached over 50% coverage, while the only one (**Cameroon**) achieved its target (having set a very low goal).

44. In **East, South and South-East Asia**, where 75% of HIV infections occur among key populations, access to treatment/prevention for men who have sex with men averages just 24%. Only **Bangladesh, Indonesia, Pakistan, Thailand** and **Vietnam** even reported on ART coverage among people who inject drugs, with all levels under 5%. In **EECA** countries such as **Ukraine**, people who use drugs are just 8% of those receiving ART, despite accounting for 34% of HIV cases.

45. The scale-up of ART remains limited by a wide range of factors at different levels [Figure 5]. Prominent examples include the: stigma associated with HIV; discrimination by health workers; low community

> *"Because of some functional gaps, people are not able to access the services at the right time, when they are really required. By the time they access the services; they are dying because of the severity of the infection."*
> Country report India, INP+

[8] Note: Partners reported a degree of confusion around ART data due to the change in WHO's guidelines in 2009 (*Rapid Advice: Antiretroviral Therapy for HIV Infection in Adults and Adolescents*, WHO, 2009). It was not always clear whether country reports were using old or new criteria for eligibility.

sector involvement in treatment interventions; low availability of/investment in care, support and impact mitigation (such as income generation); and late diagnosis of HIV status. While all countries appear to provide ARVs free in government facilities, there can be hidden costs, such as monthly service fees, hospital expenses and high costs for CD4 and viral load tests.

46. Nationally, governments such as **India, Sri Lanka** and **Thailand** and **Peru** have successfully lowered the prices of ARVs, especially through the production of generic drugs. Meanwhile, while many countries appear to provide ARVs free in government facilities, there can be hidden costs, such as in **Ghana** (monthly service fees), **Peru** (hospital expenses) and **Indonesia** (where costs for CD4 and viral load tests, etc., account for 50% of the monthly expenditure of people living with HIV). There are also inconsistencies: in **China**, while first-line drugs are free, second-lines ones are not; in **Senegal**, while the policy is for free monitoring tests, users have to pay during stock-outs of governments supplies; and in **India**, while ARVs are free, drugs for opportunistic infections are prohibitively expensive.

Figure 5: Examples of barriers to access to HIV treatment cited ICASO partners

Individual and community level:

- Stigma associated with ART services
- Stigma and discrimination of key populations, such as transgender people and people who use drugs
- Poor nutritional status and support for people living with HIV who are in poverty
- Low levels of home and community care services

Services level:

- Stigma and discrimination by health care workers
- Weak case detection systems
- Low ART capacity and expertise among health care workers
- Low motivation among over-worked and under-paid health workers
- Costs of ART services - both direct (drugs, tests, etc.) and indirect (transport, lost wages, etc.)
- Low provision and access to specific ART services for key populations, such as people who use drugs
- Long distances to ART services in rural areas
- Low number of services, particularly in large or geographically complex countries
- Political limitations to provision of ART services in institutions, such as prisons
- Low confidentiality within ART services

Systems level:

- Slow or inadequate decentralisation of ART services
- Bureaucratic procurement processes
- Stock outs of ARVs, test kits, drugs for opportunistic infections, etc.
- Lack of specific supplies, such as reagents for CD4 counts and genotyping
- Lack of provision of specific types of drugs, such as second line ART for children
- Poor coordination of services, such as for ART and opportunistic infections
- Poor links between services for ART and other areas, such as needle exchange
- Limited choice of drugs or use of regimes compared to international guidelines
- Non-inclusion of private sector or international providers in health information system
- Community sector not institutionalized into country's care and treatment services)

Policy and funding level:

- Low political will to involve community sector in provision of treatment
- Insufficient state funding for ART
- Insufficient overall funding for ART
- High pharmaceutical prices
- Challenges in management of Global Fund grants restricting future funds for ART
- Delays in receiving funding from donors
- Strong dependence on Global Fund resources for ART
- MoH budget allocating little to care and support
- Oppressive laws, for example against drug use

47. Across the regions, challenges are reported in supply chain management (additional universal access indicator 3). Persistent treatment interruptions and stock outs were reported throughout in many countries **(Albania, Belarus, Georgia, Macedonia, Romania** and **Morocco)**. Countries in **Latin America** highlighted the lack of medicines to treat opportunistic infections, as well as reagents for CD4 counts, viral load test and genotyping. Across the regions, particular issues around availability and supply were reported in relation to second and third line drugs for HIV.

48. In reporting on universal access recommended indicator 1 (percentage of those on ART still alive after 12 months), some progress was seen. Client retention levels of 80% were seen across **Latin America.** In **Asia**, networks of people living with HIV played an important role in supporting adherence, helping to improve retention of ART clients to levels of 80%. However, across a range of contexts, challenges persisted with adherence and related problems, such as drug resistance.

49. Across all regions, issues of opportunistic infections were raised. In **Ghana,** in 2009 only 20% of adults and 8% of children in need of Cotrimoxazole received it – contributing to the country only achieving 32% of its target for treatment of opportunistic infections. Similar gaps remain in relation to co-infection. In the **EECA**, most countries have treatment protocols in place, based on good practice specific to the region as advised by the UN. However, implementation remains challenging. For example, the hepatitis C vaccine (recommended for people living with HIV) and treatment for hepatitis C are rarely available (although there are exceptions, such as **Macedonia** – which recently included hepatitis C medicines on its Essential Medicines List). The situation in the region also highlights the lack of treatment services targeted to the specific needs of key populations. Here, where drug use is a critical issue within many epidemics, less than 2% of people that use drugs in **Ukraine** and 1% in **Belarus, Georgia** and **Kazakhstan** receive opiate substitution treatment (despite WHO recommending levels of 20%-40%).

50. Such limitations can particularly affect key populations – a situation exacerbated by the lack of disaggregated data on coverage. In **EECA**, only 4 out of 12 countries reported on coverage of ART for people who use drugs, while in **Asia**, no countries reported on pediatric ART.

Finding 7: Progress made on universal access to human rights

51. In some countries, progress has been made in national legislation and policies to protect the rights of people living with HIV. However, the rights of key populations remain largely neglected.

The 2010 process to review universal access provided a strategic opportunity to highlight cases of discrimination and building understanding among national stakeholders of how human rights abuses hamper public health objectives

52. Widespread criminalization of key populations and HIV transmission are fundamental barriers to universal access. This fuels, and is fuelled by, persistent stigma and discrimination.

53. Human rights have gained high profile in many national strategies on HIV. But commitments are often not put into action – with lack of actual programmes, budgets and monitoring.

54. Across the four regions, many behaviors and identities – such as sex work, sex between men and drug use – remain criminalized. According to the 2008 NCPI, 61% of the countries reported laws, regulations or policies that present obstacles to effective HIV interventions for men who have sex with men, 83% for sex workers and 61% for people who use drugs.

Little progress has been made on the human rights of key populations.

55. In **EECA,** there is increasingly progressive legislation on HIV and negative, even *regressive*, measures on drug use. Legislation for services related to drug use were cited as a barrier in many other contexts, such as in many countries in **Asia**, where laws prohibit needle and syringe programmes. Sex between men is largely criminalized across the regions. In **Africa,** sex between consenting same-sex adults is criminalized in most countries, although progress was seen in some contexts. Also across the regions, community groups report that the human rights of other sexual minorities – notably transgender people – remain largely neglected and often unrecognized within national legislation and policies.

56. In many countries, sex workers also experience routine abuse of their rights. In **Asia**, where up to 10 million women sell sex, sex work is illegal in 18 out of 26 countries. This undermines HIV interventions by *"fragmenting and stigmatizing the sex workers and turning condom possession into an act that could lead to jail."* Similarly in **Latin America**, positive legislative and policy measures on wider areas - such as SRH and women's rights (for example addressing gender based violence) - are often not applied in relation to sex workers. In **Africa**, while sex work is also predominantly illegal, there are some examples of practical 'compromises' being reached, including authorities 'toleration' of sex work that allows HIV outreach efforts.

57. In **EECA**, groups of and for sex workers and lesbian, gay, bisexual and transgender people are growing in number and engaging in advocacy. However, while promising, such groups have significant needs for capacity building and resources (including through Community Systems Strengthening resources from the Global Fund). Action by communities was also reported in **Latin America**, where NGOs have promoted the regulation of human rights mechanisms embedded in national legislation and their use when abuses occur. In **Asia**, national and regional key population groups and networks have led advocacy to ensure that key populations' rights stay on political agendas.

Viewpoints 3: Universal access to human rights

"Human rights violations, stigma and discrimination have consistently impeded progress in treating HIV in the country and have compromised the effectiveness of the HIV response. The creation of a culture of fear and silence around this response has siloed the prevention efforts, the attention to and the treatment of HIV. This atmosphere promotes intolerance, foments ignorance, creates doubts regarding prevention and the self-protection and impedes the dissemination of basic data about the transmission and the prevention of HIV." Colombia report, Liga Colombiana de Lucha contra el Sida

"Unsupportive legal environments and widespread stigma are the main obstacles to universal access for key populations in Asia. Persistent criminalization of certain behaviours, gender identities and occupations is greatly hindering national responses by driving underground those groups who are most at risk of infection. There is an urgent need to improve the monitoring of human rights violations for key populations. Even in countries that have introduced laws and policies to protect people living with HIV and other key populations, these are not well implemented. There is a need for much stronger leadership in these areas from national governments, and increased advocacy from the community sector." Asia regional report, APCASO

RECOMMENDATIONS

58. For all aspects of universal access, ICASO partners provide concrete recommendations of **actions to scale-up and accelerate** responses to HIV. The community sector is central to many of these – potentially providing the reach, creativity and quality of services and support needed to make universal access a reality.

59. Globally, the inputs of the community sector can be summarized as a **6-step Call to Action** for **all relevant stakeholders**. It is recommended that national governments, multilateral agencies, donors and the community sector (including people living with HIV and key populations) work *together* to:

1. **'Know your epidemic' – more now than ever:** Using evidence (including from the community sector) to identify strategic national priorities and develop, review and report on a full set of relevant targets for universal access. Ensure that these are disaggregated to specific vulnerabilities (such as access to prevention of vertical transmission for women from key populations) and combine attention to both quantity (i.e. coverage) and quality (such as confidentiality and human rights).
2. **Develop a bold plan to address gaps and achieve scale-up:** Using the findings of the 2010 country reviews and ICASO's research to challenge 'business and usual' and identify what needs to stop, start or change. Developing a proactive, ambitious plan to address the identified gaps and weaknesses (such as in programmes for key populations and women).
3. **Aggressively tackling the major, entrenched barriers to universal access:** Focusing attention on:
   - **Socio-political barriers**, such as stigma and discrimination, gender inequality and human rights abuses, especially as affects people living with HIV, key populations and women.
   - **Structural and systems barriers**, such as poor supply chain management, stock-outs of essential drugs and both direct and indirect costs of services.
4. **Maximize the contribution of the community sector, including people living with HIV and key populations.** Including by:
   - **Recognizing the critical contribution of the community sector in the scale-up to universal access** and better integrating it into key strategies to accelerate impact.
   - **Listening and responding to community perspectives on 'what needs to be done'** for countries to accelerate towards universal access [see reports from ICASO's partners].
   - **Enhancing the on-going role of the community sector in national responses**, including by: investing in relevant capacity building (such as in advocacy and M&E); building infrastructure and reach (including through Community Systems Strengthening); ensuring full and meaningful involvement in national decision-making; and ensuring adequate funding (including from domestic sources).
5. **Target resources where they will make a difference:** 'Making the money work' by channeling existing resources to evidence-based priorities and ensuring transparency and participation in budgeting and resource allocation for universal access.
6. **Plan for long-term financial commitments:** Making a realistic assessment of current and future demand and strategy for increasing funding and planning for long term investments from both domestic and international sources, especially through the Global Fund.

THIS REPORT IS DEDICATED TO THE MEMORY OF OUR FRIEND AND COLLEAGUE ROBERT CARR

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