Chapter 12

Multisectoral HIV/AIDS Approaches in Africa: How Are They Evolving?

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Introduction

The response to HIV/AIDS in Africa has evolved considerably since the first cases were reported on the continent in the early 1980s. After the initial medical and public health responses through the mid-1990s, there was an enormous expansion in the scope of the strategic approaches and level of political and financial commitment to fight the disease. In the absence of a vaccine or cure, the global response expanded far beyond the traditional confines of the health sector. Perceiving strong links between AIDS and the greater development processes, national and international organs reached out to a wide array of stakeholders to implement a broad multi-sectoral agenda. This expansion in vision was accompanied by a corresponding development of institutional structures and coordination mechanisms. Efforts to extend, harmonize, and improve the management of the multisectoral response are very much continuing today.

Early in the new millennium, a very powerful new intervention was introduced into the arsenal against global HIV/AIDS. Already available in the developed countries, antiretroviral treatment (ART) was shown to effectively delay the progression of the disease in low-resource developing country conditions. A combination of medical advances, research, advocacy, and a very substantial upswing in donor funding allowed the global community to commit to universal access to these life-saving medications by 2010. The myriad of challenges to such a huge campaign, once seen as entirely insurmountable, is now seen as merely daunting.

These major trends have resulted in an HIV/AIDS landscape characterized by high-level international commitment to combating HIV/AIDS in a coordinated,

multisectoral, participatory, large-scale, evidence-based manner. In this chapter we describe the evolution of multisectoral HIV/AIDS (MSHA) in the context of the rapid scale-up of the international response to HIV/AIDS and the introduction of ART. We identify the challenges and opportunities for the next phase of HIV/AIDS in the context of this mounting response.

We find that the multisectoral approach has moved beyond rhetoric into national and donor strategies but that it needs a more substantial conceptual framework as well as mechanisms for tracking, evaluating, and prioritizing multisectoral interventions. This is especially true as increased resources are flowing into the costly campaign to provide universal access to AIDS treatments. Examining this evolution from the broader development perspective, we also argue for the need to reevaluate the conceptual separation of HIV/AIDS and public health and consider resituating it in the domain of public health with strong conceptual and organizational links to other important national development efforts toward the Millennium Development Goals.

The Health Response

The first cases of AIDS in Africa were reported in the early 1980s (WHO 2001). HIV sentinel surveillance systems began to be established at that early stage, primarily drawing data from pregnant women at antenatal clinics. Financed and led primarily by National Ministries of Health and treated as emergency measures, initial control efforts focused primarily on blood safety protocols. For example, in 1987, a short-term emergency plan was invoked in Zambia to ensure safe blood and blood product supplies.

In the mid- to late 1980s, preliminary scientific evidence began to appear suggesting that HIV in Africa primarily affected unmarried young and middle-aged people, most severely along specific transmission routes. Simultaneously, this period saw a steady trend of global mobilization against AIDS characterized by increasingly widespread attempts to measure seroprevalence and prevention campaigns emphasizing education, information, and human rights. In Africa, the World Health Organization's Global Program for AIDS had by 1990 provided technical assistance to 123 countries to develop short-term plans and had mobilized funds for 65 countries primarily for national public education campaigns and HIV surveillance, with some focus on blood screening, guidance care and counseling, and management strengthening (Slutkin 2000, pp. S26–S27). Progress was limited, however, and resources were scarce.

The early 1990s, however, saw dramatic increases in the number of people living with HIV/AIDS in Africa. In 1992, the South African National Health Department

reported that the number of recorded HIV infections had increased 60 percent in the previous two years, and the number was expected to double in 1993 (London School of Hygiene and Tropical Medicine 1993). This explosion caught the world by surprise. According to WHO, the infections that had occurred by the year 2000 were three times greater than 1991 expectations (WHO 2001). The rapid spread of the virus during the 1990s was then followed by waves of rising death rates and growing numbers of orphans.

As a result, HIV/AIDS began to be recognized as a long-term issue requiring a more comprehensive public health approach. At the same time, research was providing new understandings about the virus. Several studies indicated that HIV was disproportionately affecting young women in their reproductive ages. Antenatal surveillance in several countries indicated high HIV prevalence among pregnant women. And, in 1994, medical research established ways to prevent mother-to-child transmission of HIV/AIDS through cesarean sections (Dunn et al. 1994), AZT (Connor et al. 1994), and Nevirapine (HIVNET012 trials). By the middle of the 1990s, broader public health interventions came to the fore: interventions to change sexual behavior; the prevention and treatment of sexually transmitted infections; programs to reduce risk and harm among injecting drug users; and initiatives to reduce the risk of mother-to-child transmission.

Rethinking the Fight Using Multisectoral Approaches

At the beginning of the 1990s, the battle against HIV/AIDS was being waged primarily by ministries of health through clinics and hospitals. As the prevalence continued to soar and the multiple waves of impacts devastated communities of Southern and Eastern Africa, responses restricted purely to the health sector seemed inadequate. The mounting pressure led to a great expansion of the battle conceptually, organizationally, and financially, with a focus on multisectoral approaches.

Multisectoral Stakeholders and Activities

Although the AIDS literature never rigorously defines the term, multisectoral approaches to HIV/AIDS are those seeking to reduce HIV prevalence, provide care and treatment to persons living with HIV/AIDS (PLWHA), and mitigate the impacts of the epidemic on affected populations by employing an appropriate mix of health- and non-health-based interventions and involving a broad array of stakeholders in their design and implementation.

By the mid-1990s, governments in the hardest hit countries in Africa started extending AIDS-focused public health interventions throughout government agencies

and, eventually, beyond. They set up workplace AIDS policies and programs to promote prevention in other line ministries (agriculture, justice, etc.), usually through an AIDS focal point. Interventions included HIV/AIDS awareness and education campaigns carried out in ministries, offices, schools, and farmer field schools. Likewise, condoms started being distributed to high-risk populations at sites such as truck stops, border crossings, and places of work. Testing, counseling, and treatment services were extended in nontraditional workplace settings (Nathan 2002). As nongovernmental actors emerged as key players in global HIV/AIDS, thinking around HIV/AIDS evolved and resulted in widening recognition of the important role of NGOs, FBOs, CSOs, and the private sector in the HIV/AIDS response. At the same time, administrative reforms under full swing in many African countries led to the creation of AIDS task forces at district level or lower. Thus, public health interventions began to be mainstreamed through all levels of government and throughout the economy.

Simultaneously, as studies were released on the impact of AIDS on various sectors of the economy, the nature of HIV/AIDS responses was modified in a subtle way. Recognizing these impacts, government ministries, NGOs, and private sector firms alike developed responses motivated by the need to protect their own operations rather than simply serving as venues for ministry of health efforts to reduce HIV prevalence. Some of these actions focused on prevention, such as the addition of an HIV/AIDS awareness component to the 1999/2000 Zambian postharvest survey for survey field staff to be passed on to survey respondents to reduce losses in agricultural productivity (USAID 2003). Others combined prevention and mitigation, such as toolkits for small businesses to use in developing workplace AIDS programs designed to assess and lessen the economic impact of the disease on their operations.

Over time, multisectoral programming became more sophisticated. NGOs in particular piloted programs to support PLWHA and their families through a continuum of care, treatment, and mitigation efforts related to home-based care, psychosocial support to address emotional needs, home gardens and food aid to improve nutrition and incomes, vouchers for legal services to protect assets, and lighter plows and subsidized fertilizers to support incomes (USAID 2003).

As the portfolio of HIV/AIDS interventions expanded, there was increasing recognition of the need to link interventions by providing a comprehensive package of HIV and non-HIV services to target populations. The best examples come from the domain of support for orphans and vulnerable children. The 2004 *Framework for the Protection, Care and Support of Orphans and Vulnerable Children Living in a World with HIV/AIDS* brings together five strategic pillars: strengthening family capacity, mobilizing community-based responses, providing essential services,

improving policy and legislation, and advocating for a supportive environment (UNAIDS 2004e).

National and International Multisectoral Organizations

As the concept of multisectoral HIV/AIDS (MSHA) evolved, so too did the national and international institutional architecture governing the HIV/AIDS response. In keeping with the underlying public health approach, the early HIV/AIDS efforts were coordinated nationally by ministries of health and internationally by organizations such as the World Health Organization. Over time, and reflecting what would become known as the "exceptional nature of HIV/AIDS" (UNAIDS 2005b), an entirely new set of institutional arrangements has sprung up.

As the HIV/AIDS crisis gained momentum, African governments in heavily afflicted countries set up national AIDS councils (NACs), largely under the supervision of ministries of health. Towards the late 1990s, however, fueled by the need to mobilize the entire public sector, NACs came under the direct supervision of the executive (either the president or prime minister) and represented at the ministerial level by all line ministries. With the increasing profile of nongovernmental actors, most NACs formed technical committees composed of the broader array of stakeholders.

In general, NACs are responsible for (1) guiding the elaboration, approval, and revision of national HIV/AIDS strategy and action plan, (2) defining policies, (3) approving large projects with a national scope, (4) reviewing and approving annual workplans and global budgets, (5) reviewing progress in the implementation of the program, and (6) serving as the lead advocate for attention to the HIV/AIDS epidemic (Brown, Ayvalikli, and Mohammad 2004, p. 21). Multisectoral from their inception, NACs oversee all aspects of strategic planning, decisionmaking, and resource allocation around HIV/AIDS in their respective countries. By 2004, 21 of 27 UNAIDS country offices reporting from SSA had a NAC (UNAIDS 2004c).

The creation of multisectoral structures at the national level was accompanied by a parallel set of changes at the international level. Set up in 1986, WHO's Special Program on AIDS, using resources from the Global Program on AIDS trust fund, focused primarily on the public health measures described above. From 1987 to 1990, the program contributed to developing the first national strategies, promulgating widespread public information campaigns, and promoting human rights as well as emphasizing the need for a rapid, massive, and multisectoral response. In mid-1993, six United Nations organizations, including WHO, began to seek agreement on forming a novel joint and cosponsored UN program on HIV/AIDS

(WHO 1995). In July 1994, the Economic and Social Council of the United Nations resolved to form a coordinating group to spearhead the global response to the epidemic, reinforce national capacities to develop comprehensive strategies, implement effective HIV/AIDS activities across a wide range of sectors and institutions, and raise funds and commitments for the response (UN 1994). The resulting body, UNAIDS was made operational in 1996 and at the time of this writing, in 2005, describes itself as having driven "a unique, multistakeholder response" (UNAIDS 2005b, p. 4). The UNAIDS multisectoral response includes supporting the effectiveness of the UN system, working closely with AIDS-related civil society and people living with HIV, and engaging nontraditional partners in fighting AIDS, such as the media, faith-based organizations, business, sports organizations, uniformed services, and the labor movement (UNAIDS 2005b, p. 12).

Although not strictly speaking an institution, the World Bank's Multicountry AIDS Program (MAP) for Africa has been specifically designed to support implementation of national multisectoral HIV/AIDS strategies and action plans (World Bank 2002, 2004). In fact, the existence of a NAC became a prerequisite for participation in the program. MAP's purpose is to avert millions of HIV infections, alleviate suffering for tens of millions, and help preserve the development prospects of a large number of African countries. The first phase, MAP1 was approved in 2000, funded at US$500 million, and put into operation in 2001. In Fiscal Year 2001, the World Bank's contribution to HIV/AIDS in Africa was greater than in all previous years combined. Particularly supporting the decentralized aspects of multisectoral approaches, a large share of MAP resources are directed to local communities for designing and implementing HIV activities tailored to their specific conditions. In the second phase of its estimated 12- to 15-year commitment, the World Bank has committed another US$500 million under MAP2 to expand efforts to new countries, to pilot test ARTs, and to support cross-border initiatives (World Bank 2002).

As follow-up to the 2001 UN General Assembly Special Session on AIDS, the Global Fund to Fight AIDS, Tuberculosis, and Malaria (GFATM) was established at the beginning of 2002 (GFATM 2004). By the end of 2004, the Global Fund had disbursed US$402 million for HIV-related grants (UNAIDS 2005a), representing 56 percent of total Global Fund disbursements (31 percent and 13 percent going to malaria and tuberculosis, respectively). Sixty-one percent of the HIV/AIDS funds went to Sub-Saharan Africa; 49 percent of HIV/AIDS funds disbursed through the Global Fund during this period were earmarked for drugs and supplies (e.g., ARV drugs). Finally, in many cases, many NACs also serve as the Country Coordinating Mechanisms for GFATM activities.

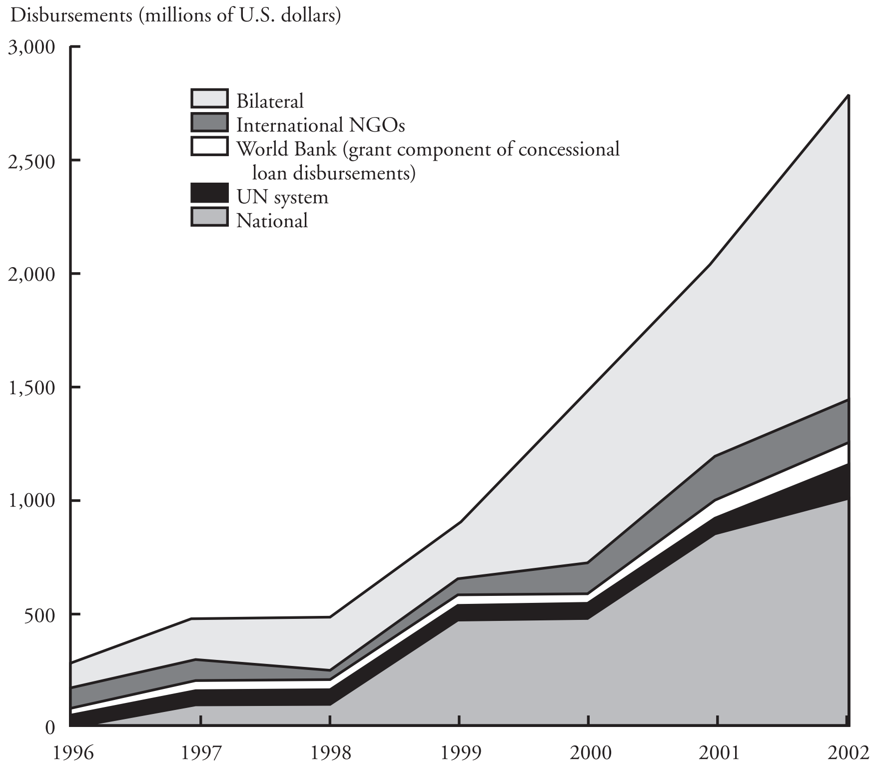
Greater Political and Financial Commitments

Globally, there has been a growing recognition and formal commitment to the idea that effective responses to the HIV/AIDS epidemic include multisectoral approaches to preventing the disease, caring for and treating its victims, and mitigating its effects. The Abidjan Declaration of 1997 committed African mayors and municipal leaders to promoting and co-coordinating local multisectoral approaches for HIV prevention and the care of infected and affected people. The Abuja Declaration of April 2001 signed by African heads of state acknowledged the role played by poverty, poor nutritional conditions, and underdevelopment in increasing vulnerability to HIV/AIDS. In June 2001, 189 countries of the United Nations General Assembly Special Session (UNGASS) signed the Declaration of Commitment on HIV/AIDS to ensure the development and implementation of multisectoral national strategies and financing plans for combating HIV/AIDS by 2003. This commitment has continued to accelerate (Fig. 12.1). Global spending on AIDS programs in low- and middle-income countries has increased nearly 15-fold since 1996, when UNAIDS was founded to coordinate all AIDS-related activities of the UN system. Although not shown in the figure, annual institutional spending on HIV/AIDS rose even further in 2004 to US$6.1 billion.

This amount represented contributions in 2003 from domestic sources (national governments and households, 42 percent), bilateral donors (23 percent), international nongovernmental organizations (NGOs), and the multilateral (Global Fund, UN, and the World Bank, 26 percent). A large portion of these funds comes from just a few donors. The most recent data (2004) indicate that the United States contributes nearly 50 percent of all bilateral contributions to global HIV/AIDS in developing countries (excluding funds for GFATM and research), and the United Kingdom 21 percent; the European Union as a whole, Canada, Germany, and Japan contribute shares of about 3 to 4 percent each (UNAIDS 2004a,b,f, 2005a).

Although funding continues to surge, it falls well behind the ever-increasing costs of combating the epidemic. UNAIDS estimates there will be a funding gap of at least US$18 billion from 2005 to 2007 (UNAIDS 2005a). Addressing this gap raises several key issues. First is the ongoing need to greatly improve financial tracking and costing. Great strides are being made by UNAIDS, World Bank/MAP, donors, and in-country NACs, but there is a long way to go. At present, it is very difficult to track the true costs and available funding for the full multisectoral response to HIV/AIDS. Some of the problems arise from the sheer difficulty of gathering reliable information on key components of spending. Others are more bureaucratic, such as developing codes for dual-purpose interventions (OECD/DAC and UNAIDS 2004), which many multisectoral activities are, or putting in place

Figure 12.1 Institutional HIV/AIDS spending, 1996–2002



Source: UNAIDS (2004b, p. 15).

the data collection and analysis processes needed to budget and monitor the implementation of national strategic plans. Finally, there are strategic issues. Most donor strategies reflect a strong multisectoral orientation either explicitly or by endorsing a wide array of multisectoral interventions (CIDA 2002; GTZ 2003; DFID 2004a,b; GTZ 2005). The rules governing the disbursement of funds under the U.S. government's PEPFAR program make it difficult to use these funds for multisectoral interventions (United States Department of State 2004, 2005a,b; USAID 2004).

The Era of ARVs

Recent results presented at the 11th World AIDS Conference in 1996 in Vancouver established the efficacy of antiretroviral therapy (ART), and in the course of the

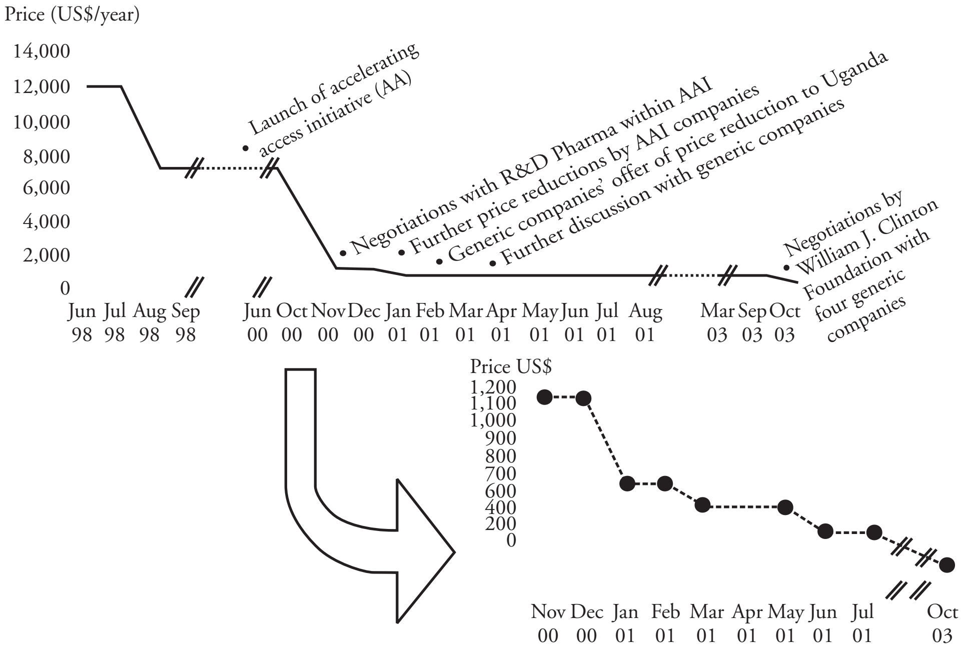
next few years, antiretroviral (ARV) drugs became a major tool in the arsenal for combating HIV/AIDS in developed countries (Katzenstein, Laga, and Moatti 2003, p. S1). To the great frustration of many in Sub-Saharan Africa, the high cost of the drugs and the considerable logistic challenges of rolling out drugs to such a large, impoverished community seemed insurmountably daunting.

In May 2000, the Accelerating Access Initiative (AAI) was launched as a cooperative endeavor of UNAIDS, the WHO, UNICEF, UNFPA, the World Bank, and five (later six) pharmaceutical companies. The purpose was to find ways to expand safe access to affordable HIV medicines in developing countries. The drug companies rapidly lowered prices as countries negotiated batch orders; the companies also gave large price reductions to NGOs, private sector employers, and health care providers. At the same time, all of the 19 national governments that entered into supply agreements under the AAI lifted taxes and trade barriers to the medications. Some also brought in highly price-competitive generic drugs from the Indian drug manufacturer Cipla (WHO 2002).

The effect of these initiatives on ARV prices in Africa was dramatic (see Fig. 12.2), falling from about $12,000 in 1999 to $300 per person per year in 2004. Falling ARV prices provided treatment advocates with the momentum for building political and financial commitment to widespread drug access in the developing world. So too did evidence from initial trials in Cote d'Ivoire, Senegal, and Uganda that drug resistance in Africa could be kept to levels at or below levels in Western countries (Katzenstein, Laga, and Moatti 2003, p. S1), and the argument, drawn in part from the experience of cities such as San Francisco, is that the availability of treatments motivated people to prevent and test for HIV. ARVs continue to be seen as a critical tool for mitigating the impacts of HIV on affected communities by extending lives and livelihoods.

International commitment to treatment grew rapidly. As early as 1997, the World Bank published a groundbreaking report (*Confronting AIDS: Public Priorities in a Global Epidemic*) proclaiming that treatment needed to be an integral part of AIDS strategies. In addition to its express commitment to multisectoral approaches, the Declaration of Commitment to HIV/AIDS signed unanimously by all 189 UN members in 2001 recognized the right of all people living with HIV in low-income countries to care and treatment. Widespread commitment emerged at the International AIDS Conference in Barcelona in July 2002 to the goal of extending ARV treatment to millions of people in developing countries. This consensus was rapidly consolidated by the end of the year in the World Health Organization/UNAIDS "3 by 5" Initiative (WHO 2005) to ensure that 3 million people living with HIV/AIDS in developing countries have access to antiretroviral treatment by the end of 2005 (UNAIDS 2004a). In July 2003, at their special summit on

Figure 12.2 Prices (US$/year) of a first-line antiretroviral regimen in Uganda, 1998–2003



Source: http://www.unaids.org/html/pub/topics/epidemiology/slides12/bkk04slide034_en_ppt.ppt#256,1, Slide 1.

HIV/AIDS, the Southern African Development Community (SADC) countries issued the "Maseru Declaration," which combined an explicit multisectoral approach to combating HIV/AIDS with a strong priority on scaling up care, treatment, and access to antiretroviral drugs (SADC 2003).

Donors responded by funding treatment programs. In early 2001, Uganda was one of the first countries to start using World Bank/MAP money for providing ART. Since its inception, the Global Fund has disbursed US$272 million for HIV/AIDS in Africa (49 percent of total Global Fund disbursements go toward drugs and supplies). Initiated in January 2003, the U.S. President's Emergency Plan for HIV/AIDS Relief (PEPFAR) represents one of the largest sources of ARVs in the developing world. One of the main PEPFAR goals is to use 55 percent of its resources to provide treatment for 2 million HIV-infected people in the first five years of the program.

As a result of this tremendous organizational focus, WHO estimates that the number of Africans receiving ARV therapy approximately doubled from 150,000 to 325,000 between June and December 2004. Coverage, however, remains very low. Only 8 percent of those currently requiring medications are receiving them (WHO 2005).

Challenges and Opportunities Going Forward

The urgent need to stop the rapid spread of the incurable, deadly, and devastating HIV virus has prompted great activity and experimentation on the part of the national and international communities. An initial health-based response was followed, in the absence of vaccines, cures, or even effective treatments, by broad-based multisectoral efforts involving to varying degrees all levels of government and stakeholders. After a slow start, life-extending ARVs are becoming available to the vast number of HIV-infected persons in developing countries, including the 66 percent who live in Sub-Saharan Africa.

This complex and rapidly evolving situation requires immediate efforts to harmonize concepts, priorities and strategies, implementation plans, measures for monitoring and evaluation, and resource tracking. Responding to the cacophony of actors and approaches, UNAIDS and its partners are promoting the "Three Ones" principles, which call for one agreed-on national framework of action against AIDS in each country that unifies all partners; one national AIDS coordinating authority, with a broad-based multisectoral mandate; and one agreed-on country-level monitoring and evaluation system. The growing commitment to the "Three Ones" poses significant challenges and opportunities going forward.

Aligning Strategic Frameworks

If the many players in the AIDS arena in each country are to operate under a unified national framework, that framework must be up-to-date, robust, and clearly prioritized, with meaningful objectives, monitoring plans, and resource allocation processes. Aligning strategic frameworks requires efforts on many levels.

First is to integrate the modalities of extending universal access to ARV therapies. By the late 1990s, most of the high-prevalence African countries had drafted comprehensive, multisectoral national AIDS strategies and policies. Because only 43 percent of these have been updated in the last two years (UNAIDS 2004c), many of the older national strategies do not yet reflect plans for extending ARVs. Countries need strategies to deal with the many moving pieces: procurement and supply management, strengthening health systems, training health workers, assuring quality and

accreditation, monitoring treatment and drug resistance, supporting home-based care, developing appropriate nutritional components, and ensuring equitable treatments for women and children (WHO 2005).

Second, NACs also need to work with their stakeholders to put a more solid foundation under the multisectoral components of their strategies. Multisectoral responses have been formally introduced in a large number of ministries, typically 20 or more in each country, but the quality and implementation of those plans has been uneven. Some sectors have had more success mainstreaming an HIV/AIDS response than others. Predictably, health ministries have been most active in designing and implementing programs to address HIV issues faced by their staff and their constituencies (World Bank 2004; Futures Group, Research Triangle Institute, and the Centre for Development and Population Activities 2002). A review of SADC HIV/AIDS policies conducted in 2002 found that the education ministries were also widely engaged to the extent of having detailed implementation strategies. Other ministries tended to have policies but no action plans (Futures Group, Research Triangle Institute, and the Centre for Development and Population Activities 2002). A 2003 UNAIDS survey in 63 countries (worldwide) found only 13 percent had actually made progress in implementing sectoral plans (UNAIDS 2004a). In 2004, World Bank evaluations found these sectoral efforts to be "somewhat half-hearted . . . cookie cutter" plans that do not reflect local situations (Brown, Ayvalikli, and Mohammad 2004; World Bank 2004). Further, although ministries often have workplace action plans and programs, many have not taken the next steps to address the HIV/AIDS issues related to their interactions with their constituencies (e.g., farmers, students, trade associations).

Third, revised multisectoral strategies must find a way to motivate genuine private sector involvement. Although studies show that private households bear a tremendous share of the costs associated with HIV/AIDS (see Box 12.1), involvement by the business community appears to be fairly modest (Fig. 12.3). The figures shown do not capture the contribution African businesses may make to HIV/AIDS prevention, care and treatment, and mitigation in their own work settings. However, a recent study by the World Economic Forum suggests that such investments are also fairly limited, especially in relation to the high level of concern about HIV impacts expressed by the business managers surveyed (World Economic Forum 2005).

There are many reasons for what B.A. Brink, senior vice-president for health at Anglo-American, calls the "disappointing global business response to HIV/AIDS" (World Economic Forum 2005, p. 4). At present, there are few incentives. To address the problems of poverty and inequity, donors are directing huge sums of public funding through governments and NGOs to subsidize AIDS-related drugs

Box 12.1 Out-of-Pocket Spending on HIV/AIDS by African Households

- In Burkina Faso in 2003, household spending was 14.3 percent of the total expenditure on AIDS; this constituted 98 percent of total private expenditures on HIV/AIDS and almost double the government's share.
- In Kenya in 2002, households were 45 percent of the total.
- In Rwanda in 1998, households bore 93 percent of all HIV/AIDS spending; by 2002, a large influx of donor funding reduced the burden on households to 13 percent. But even at that level, households still far outspent government, which accounted for only 8 percent of total HIV spending.
- In Zambia as in Burkina Faso, the household share was nearly twice the government's share (29 versus 17 percent for Zambia; 20 versus 10 percent for Burkina Faso).

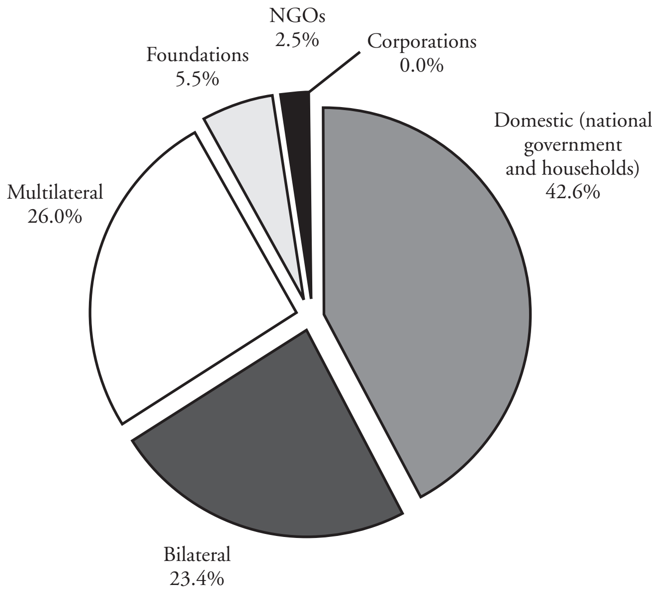
These patterns are repeated around the world.

Source: Data are from UNAIDS (2004d).

and health services, undercutting the potential for the private sector to compete in these domains. In addition, not all companies have the wherewithal to undertake their own programs. Finally, the private sector often faces high "transaction costs" of dealing with bureaucratic NACs (Brown, Ayvalikli, and Mohammad 2004).

Carrying through on a multisectoral response to the AIDS epidemic that sustainably involves the private sector requires radical thinking on how to improve incentives for partnership and even handover. WHO, UNAIDS, and USAID are experimenting with approaches to expand the private sector's role in delivering AIDS services to the general public. World Bank reports recommend a combination of subsidies and contracts to private businesses to increase their involvement while addressing critical public sector constraints. Brown et al. note that smaller enterprises that are willing but unable to provide HIV/AIDS services outside to their staff "should be treated as any civil society NGO and receive full grant financing" (Brown, Ayvalikli, and Mohammad 2004, p. 52). Noting the key role of the private sector in supply chains for health services and drugs the World Bank has

Figure 12.3 Contributors to HIV/AIDS spending in 2003



Source: UNAIDS (2004f).

experimented with in MAP projects with contracting financial management services (Senegal), AIDS-related accounting and other traditional project management services (Cape Verde and Zambia), and disbursement services for civil society grants (Kenya) (Brown, Ayvalikli, and Mohammad 2004, p. 78). In addition to evaluating and extending these pilot efforts, there is an ongoing need for substantial studies and debate on how to motivate the private sector to play a sustained, profitable, and equitable role in the rollout of ARVs.

Ongoing efforts to improve national coordination provide an important opportunity for donors and other stakeholders to improve the national and sectoral strategies themselves.

Governing a Multisectoral Response

The "Three Ones" calls for one national AIDS-coordinating authority with a broad multisectoral mandate. As implemented, NACs tend to be exceptional government structures, outside the usual chain of ministerial command. Although such interagency bodies have precedent in Africa and indeed elsewhere, some analysts

voice concern that they may circumvent, rather than strengthen, normal government functions. In its ongoing reviews of its MAP program, the World Bank has repeatedly signaled the problem that "the placing of the NAC Secs outside the Ministry of Health has caused resentment and confusion among health officials" (World Bank 2001, p. 12). In his assessment of AIDS governance issues, Putzel writes that

> [t]he organizational template being imposed by UNAIDS, the World Bank, and the Global Fund is not necessarily conducive to developing an effective battle against the epidemic. . . . The national commissions called for by the Bank and the Global Fund have tended to weaken government and overly marginalize the health sector and medical profession. (Putzel 2003, p. iv)

The large-scale rollout of ARVs again underscores the key role of the health sector in contributing to the HIV/AIDS response. As with any complicated health problem, AIDS demands the involvement of actors and interventions outside the strict confines of the health sector. But the ongoing need for a broadly participative, multisectoral approach does not obviate the basic principles of public sector management and responsibility. The World Bank recommends that NACs and NAC secretariats stick to facilitation rather than control and avoid competing with or duplicating the key role of the health sector in responding to the epidemic (World Bank 2001). Over time, there is an opportunity to learn from the success of multisectoral NACs and consider whether better linkages among all ministries on a broad range of interrelated development issues may not be a better approach focusing coordination on one "exceptional" disease.

Developing Robust Multisectoral Monitoring and Evaluation

Consistent with the final stipulation of the Three Ones principles, there is consensus that monitoring and evaluation (M&E) is critical to producing the scientific data and strategic information needed to guide the response. M&E forms integral components of World Bank, Global Fund, and PEPFAR HIV/AIDS activities. Perhaps the greatest strides have been made in Uganda, which has well-defined M&E activities, a budget, an implementation plan, indicators, and benchmarks as part of its HIV/AIDS strategic framework (Government of Uganda 2000). However, this is not the case elsewhere. The World Bank argues that "In the future, arguably the single most important role for a NAS will be to develop an integrated, fully costed, annual project implementation plan . . . with clear definition of responsibilities, outputs and budgets" (Brown, Ayvalikli, and Mohammad 2004, p. 25).

Huge sums of money are now being invested in multisectoral approaches with weak statements of how those funds are truly going to address the AIDS problem in a sustained manner. There have been extensive efforts to assess the effectiveness of the traditional public health interventions (such as condoms, VCT, STI, abstinence, PMTCT, blood safety, etc.) in terms of prevalence rates, numbers of infections averted, or cost per infection averted.[1] At present, the goals for most care and treatment interventions are tracked in terms of their outputs, not their impacts: thus, number of employees reached with workplace AIDS programs, number of patients receiving treatment, or number of home-based care visits. M&E for mitigation is at a very rudimentary stage. The major M&E systems and resource tracking models used by UNAIDS include few mitigation activities beyond orphans and vulnerable children. M&E plans typically lack indicators related to household or community food security and nutrition (beyond orphans and vulnerable children), incomes, economic productivity, livelihood and assets protection, the coverage and equity of social service provision, stigma and discrimination, and gender-based violence. Furthermore, when included, mitigation indicators typically do not capture impacts but rather only inputs and outputs such as number of orphans schooled or number of PLWHA associations formed.

There are two major reasons for this poor tracking. First, there is no clear, agreed-on, definition of multisectoralism in HIV/AIDS and how it leads to prevention, treatment and care, and mitigation. Most proclamations and donor and national strategies fail to provide a clear definition or conceptual framework for their multisectoral approach. They tend to focus on "who": government line ministries and their decentralized organs, nongovernment groups, and others. Most statements are mute on the specific objectives (expected outcomes) of their multisectoral approach and on who needs to do what to accomplish those objectives.

Thus, if AIDS funds are to be effectively directed to preventing the epidemic and lessening its impacts, the full basket of interventions must be evaluated in similar terms against well-defined goals. Efforts to refine M&E plans, now further motivated by the Three Ones, offer an opportunity to address these difficult issues. The first step must be to clarify the goals of HIV prevention, care and treatment, and mitigation. Such efforts must start with laying out a basic conceptual framework for each of these concepts that shows the distinct roles for a broad range of health and nonhealth approaches.

- For prevention, once the linkages among various multisectoral determinants of infection are explicitly formalized, they must be tested against the same standards used for other public health interventions (e.g., infections averted, prevalence). At present, there are few studies of multisectoral interventions that

express outcomes in terms of these standard HIV measures, in part because of the great complications in linking socioeconomic conditions to infections in a rigorous manner across a highly diverse range of environments and attenuating circumstances.

- For care and treatment, measures of mortality, morbidity, and disability-adjusted life years (DALYs) are likely to become more important with broader use of ARVs.

- For mitigation, some of the newer OVC indicators, which include nutritional status and other measures of welfare, may provide an opening for expanding the monitoring and evaluation of mitigation efforts beyond this one group of affected people.

The second reason for the difficulties tracking MSHA interventions is that such interventions usually have multiple objectives. The full value of their benefits cannot be captured solely in terms of their impacts on HIV/AIDS because they were designed to allow other sectors to attain their objectives in spite of HIV/AIDS. Evaluating the effectiveness of a workplace program solely in terms of number of infections prevented will miss other important impacts it may have on motivation, productivity, recruitment, and, ultimately, the bottom line for all businesses, profitability.

More profoundly, there are many development interventions that fall well outside the traditional set of HIV/AIDS activities that are likely to have a very significant impact on decreasing prevalence, improving care and treatment, and mitigation impacts. Although evidence on the direct effects of poverty on HIV is mixed, it is clear that the impoverishment of African countries has eroded their ability to put in place the health systems needed to prevent and treat the disease. Nor have these countries succeeded at creating the social and economic opportunities needed to mitigate the impacts of HIV/AIDS and potentially contribute to prevention in the first place. As terrible as the HIV/AIDS epidemic truly is, it is not the only terrible problem plaguing Africa. In spite of a plethora of studies on HIV/AIDS, there are few assessments of its impacts relative to other health problems and other nonhealth challenges to people's well-being, such as drought, food crises, corruption, wars, and slow economic growth. It may be that the next best way to improve the human condition in Africa is to invest in the roads, schools, and farms needed to eradicate poverty, hunger, and poor health conditions. At present, we simply do not have the evidence to say. Even in the face of international cries and commitments to increase development assistance across the broad array of Millennium Development Goals,

there have been few strategic or analytic efforts by either donors or national government to lay out consistent, costed, sequenced, and monitored multipronged development strategies.

Thus, one of the greatest challenges going forward is the need to develop a more robust set of M&E indicators that reflect the multiple impacts of a broad-based HIV/AIDS program that can be used to better allocate scarce funds among competing objectives. It is therefore imperative to develop the analytic framework and tools to situate HIV/AIDS in the greater development context. A truly multisectoral approach requires rigorous assessments of the returns to varying types of interventions not only in terms of HIV outcomes but also in terms of other development outcomes as described in the Millennium Development Goals, such as poverty reduction, incomes, and hunger. Such analyses should be carried out in a framework that (1) sums up joint returns of multisectoral investments in terms of their health and nonhealth impacts and (2) provides meaningful comparisons of the returns from different HIV and non-HIV interventions against a broad range of development goals.

Only with such information can scarce resources be sensibly invested among the sectors, within the health sector itself, and among the wide span of activities designed for prevention, care and treatment, and mitigation. There is great demand for this kind of information at all levels. Political discussions at the highest international levels (such as July 2005 G-8 discussions on development in Africa) as well as the ongoing technical revisions to M&E plans currently being undertaken by PEPFAR and the UNAIDS Monitoring and Evaluation Resource Group provide important opportunities to tighten the effectiveness of multisectoral HIV/AIDS investments going forward.

Summary

There have been rapid and impressive advances in the science, organizational approach, and funding to HIV/AIDS in the last two decades. National governments, with their UN and other partners, have exhibited strong multisectoral commitment and momentum, engaging a broad range of stakeholders through participatory and decentralized processes. The focus on locally driven multisectoral approaches has been supported by the creation of flexible institutional structures, such as UNAIDS, World Bank MAP, and GFATM. Donor funding has soared. In addition to donor commitments to multisectoral interventions, there have sprung up innovative management and funding arrangements, such as contracted services, pooled funding, and community funding channels designed to strengthen the multisectoral response.

However, there are still some major challenges. HIV prevalence continues to rise worldwide and, despite some important successes, in Africa. Although broadly espoused, the MSHA approach lacks a tested conceptual framework linked to defined outcomes with clear linkages to effective interventions. As a result, there is a "cookie-cutter" approach to sectoral strategies and fairly rudimentary (but improving) MSHA M&E. The rapid advance of the epidemic, the corresponding inflow of massive resources into many health and nonhealth intervention approaches, and the recent commitment to universal extension of costly treatment programs requires a careful balancing act. Although useful, broad stakeholder representation at the national level is not enough to ensure results-oriented, evidence-driven decisionmaking or effective implementation. Within the AIDS community, there is already lively discussion of the issues involved in balancing investments within the broad range of HIV activities aimed at prevention, treatment and mitigation, and research. Multisectoral approaches provide a solid foundation for designing ARV outreach programs as well as maintaining the political pressure needed to ensure equitable distribution of treatment services. However, the gaping weaknesses in the health infrastructure required to meet the 3 × 5 targets have refocused attention on the need to invest beyond HIV in strengthening the health sector more generally (WHO 2005). There is a need for better M&E information in order to make optimal choices. Unless interventions can be shown to have direct and measurable impacts on HIV/AIDS, the single largest donor, the United States, will remain cautious about using AIDS money for multisectoral interventions. Increasing commitment to the Three Ones provides a critical impetus to efforts to harmonize strategic plans, priority setting, implementation, terms, methods, and monitoring and evaluation.

There are many opportunities for both health and nonhealth specialists to work together to improve the effectiveness of multisectoral approaches to combating HIV/AIDS in this rapidly changing landscape. Possible forums include the technical committees of NACs and the Global Fund CCMs, where nonhealth specialists can provide input into strategic dialog, priority setting, implementation, and results tracking for HIV/AIDS. Mounting awareness of the links between HIV/AIDS and nutritional status creates an opportunity for nutrition and food security experts to develop these conceptual links lacking in current MSHA frameworks, provide an empirical basis for assessing impacts and costs, propose indicator and monitoring systems, and design appropriate targeted food interventions. Likewise, the food and nutrition security community is well suited to offer a broader operational definition of mitigation beyond orphans and vulnerable children.

Further, with the world focused on the calls to greatly increase the quantity and quality of assistance to Africa, the broader development community also has

an important role to play in the working with the health community to ensure the best allocation of public funds across a wide range of development goals.

Notes

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1. Libraries of such studies as well as links to AIDS costing models based on the results of such studies can be found at the web pages of the International AIDS Economics Network (www.iaen.org).

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