Positive Gains

How integrating HIV/AIDS into wider health and development programmes can foster health systems and build resilience against poverty

Promoting greater impact on health and livelihoods by moving from vertical HIV/AIDS-programming to integration

Positively Strategic

Making HIV/AIDS-programming more effective for health and development

Positively Integrated

Executive Summary

The response to the global HIV/AIDS epidemic has seen unprecedented financial and political commitment by the international community. However, 14.2 million people require treatment today and realising universal access to prevention, treatment, care and support demands a continued investment in HIV/AIDS. Instead, in 2011, resources for fighting the disease declined and expectations of the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) and other instruments were not met. At the same time, it should be recognised that health and other development priorities are also underfunded. Yet, HIV/AIDS funding has had a positive impact on wider health and development goals. The real issue is therefore not whether to fund HIV/AIDS, health systems strengthening or other development priorities, but how best to use limited funding most efficiently and effectively for greatest impact. This paper therefore focuses on the best ways for investments in HIV/AIDS to also strengthen other health and development responses – and vice versa. This can be done with strong leadership and coordination by maximising existing synergies between sectors and taking a multi-sectoral and multi-stakeholder approach. There is also a need to review the structure and length of donor funding which is generally only three years.

1 Background

Contributions to the global HIV/AIDS response from GFATM; the United States President's Emergency Plan for AIDS Relief (PEPFAR); bilateral donors; the Joint United Nations Programme on HIV/AIDS (UNAIDS); private foundations; and governments have brought unparalleled attention for HIV/AIDS and resulted in 6.65 million people now on antiretroviral therapy (ART) in low- and middle-income countries[1], and a 21% reduction in new infections worldwide.[2]

Since the beginning of donors' increased attention to HIV/AIDS, many vertical HIV/AIDS programmes have been implemented in parallel to existing fragile health and other development sectors, initiatives and structures in developing countries. This has triggered a long-standing debate about whether investment in HIV/AIDS programmes strengthen or weaken health systems and wider development efforts. Critics of HIV/AIDS programmes report links between increasing HIV/AIDS funding and reduced resources for other important issues such as sexual and reproductive health. There are also accusations that scarce personnel are siphoned off from other health care services for better-paying

HIV/AIDS jobs, although there is limited hard evidence for this. Yet, the HIV/AIDS response has made a significant contribution to the attainment of broader goals such as the Millennium Development Goals (MDGs) and the UK Department for International Development (DFID)'s priority pillars, particularly in the areas of health and poverty reduction.

In the area of health, the HIV/AIDS epidemic has strongly impacted on health systems in high prevalence countries. As more people became infected, health systems struggled to provide even basic preventive and curative care to meet the rising demand. Before ART, half of hospital beds in sub-Saharan Africa were occupied by people living with HIV (PLHIV).[3] At the same time, the health service was unable to cope due to staff's own HIV/AIDS morbidity, mortality and low morale as a result of increased workloads, exposure to HIV/AIDS and stress.[4] For example, health worker illness and death rates increased by around five times in Malawi.[5] This pressure on health systems correlated with an increase in maternal and child mortality in many countries.[6] Integration of HIV/AIDS programming into health interventions (particularly maternal health services, family planning, sexually transmitted disease testing, sexual and gender-based violence responses, TB and others) is now widely viewed as more cost-effective and efficient than the more traditional package of vertical service programming.[7] For example, DFID's "Towards Zero Infections" 2011 paper notes that the Department's "particular focus will be given to the delivery of quality integrated HIV/AIDS, TB and reproductive health services based on national and local epidemics" and that its funding for the strengthening of the broader health system will improve HIV/AIDS services.[8] HIV/AIDS and health integration leads to more effective healthcare and happier patients when all of their health needs can be met together.

With regards to poverty reduction, HIV/AIDS increases the number of dependents relying on a smaller number of productive family members.[9] It particularly affects the economically active age group which causes a dramatic impact on agricultural production, livelihoods and food security. The normal response of HIV/AIDS-affected households has been to downshift to a survival mode – with responses including self-employment, migration, reducing the number and range of crops grown, sacrificing nutritious crops for easy-to-grow ones, selling livestock or other productive assets, or taking children out of school.[10] Women and girls are particularly vulnerable as they devote more time to caring for the ill (this subject is further explored in the *Past Due: The Case for Paying Caregivers* policy brief). HIV/AIDS-affected households are less able to cope with food shortages, high food prices, famines, poor rainfall and floods.[11] In the face of these, the international community responds with short term food aid and crisis interventions that offer little value for money or sustainable livelihoods to prevent crises before they happen. By contrast, integrated HIV/AIDS and poverty reduction initiatives have proven to have a positive long-term impact on both HIV/AIDS and poverty reduction while strengthening community capacity and involvement.

Despite positive effects for broader health and development goals and continued demand for prevention, treatment, care and support the HIV/AIDS response is today facing an uncertain future. Since 2009, investment in HIV/AIDS has stopped growing and in some cases decreased. DFID bilateral funding for HIV/AIDS is expected to drop by 32% between now and 2015 despite a 92% increase in overall bilateral aid for health. GFATM has recently announced that its Round 11 funding has been delayed. At a time when scientific evidence is able to show the positive impact of early ART on the number of new infections[12], governments may be faced with rationing ART or providing suboptimal treatment.

This paper agrees with the group of academics and donors from UNAIDS, PEPFAR and others who argue that integration can achieve maximum effectiveness and impact in other health and related development sectors. The group recently proposed a "Strategic Investment Framework"[13] to achieve efficiency in programming through community mobilisation, harnessing synergies between programme elements and utilising ART as a prevention strategy. The authors calculate that "implementation of the new investment framework would avert 12.2 million new HIV/AIDS infections and 7.4 million deaths from AIDS between 2011 and 2020 compared with continuation of present approaches, [...] and the additional investment needed for this would be largely offset from savings in treatment costs alone".[14] Through its advocating of a human rights approach – universality, equity, inclusion, participation, informed consent and accountability[15] – and of integration and context-specificity the framework is in line with the comprehensive primary health care approach embraced in the 1978 Alma Ata Declaration[16].

2 HIV/AIDS and the Wider Health System

2.1 The impact of HIV/AIDS programmes on health systems

Improved access to and quality of health services: HIV/AIDS interventions such as Voluntary Counselling and Testing (VCT), Prevention of Mother to Child Transmission (PMTCT) and ART have had positive effects on the supply of and demand for health services in general. When effective HIV/AIDS treatment programmes are implemented, hospital admissions are drastically reduced and hospital beds freed up, easing the burden on health care staff throughout the system and improving quality.[17] HIV/AIDS programmes and funding have increased access to and uptake of other important health services such as childhood vaccinations, family planning, health promotion services and TB case identification and treatment (HIV/AIDS and TB links are explored further in the *Realising Commitments on TB and HIV through service integration* policy brief). For example, in Haiti, Partners in Health's HIV/AIDS programme radically increased overall patient visits at the Las-Cahobas primary health clinic, resulting in an increase in prenatal care visits and immunisations from 100 visits per day to over 500.[18] In Rwanda, basic HIV/AIDS care was added to primary health centres, contributing to increased use of maternal and reproductive health, prenatal, paediatric and general health care. HIV/AIDS programmes reach the most marginalised groups, such as men who have sex with men (MSM), injecting drug users (IDUs) and sex workers, building trust among these groups to utilise the health system in general. HIV/AIDS programmes, associated with heavy community involvement, task-shifting and decentralisation of care, also offer an important learning opportunity for other health interventions.

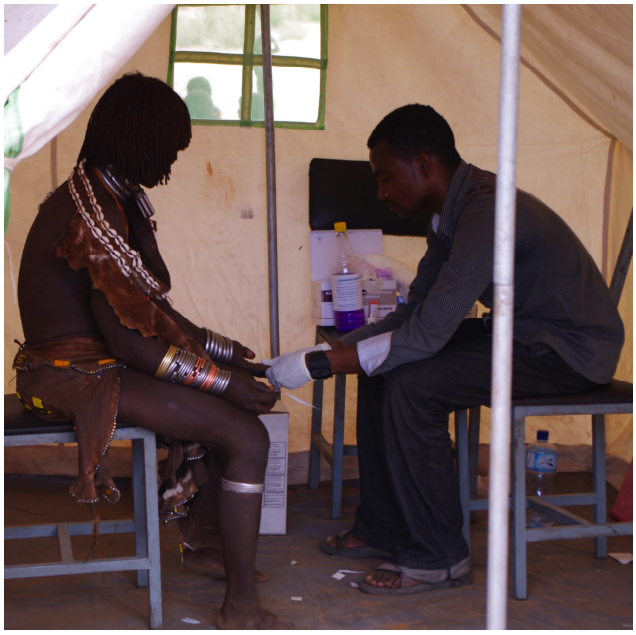
Many governments, donors and NGOs are integrating HIV/AIDS into other health programmes with good results. For example, in many countries, PMTCT services funded by GFATM are now based in government reproductive health divisions, leading to the integration of PMTCT into routine maternal health services.[19] Some PEPFAR-funded HIV/AIDS service sites are now offering cervical and breast cancer information and services and Family Health International's programmes in Kenya are screening for cardiovascular diseases.[20] In Cambodia, HIV/AIDS, TB and malaria control programmes have been integrated at the district hospital level. PROFAMILIA's (a local partner of the International Planned Parenthood Federation) successful "Models of Care" project, which began in 2004, integrated HIV/AIDS services into their existing sexual and reproductive health clinics in the Dominican Republic. Patients coming to the clinics for HIV/AIDS services follow the same intake procedures as other clients, confidentially selecting the services they need at the reception. HIV counselling is conducted in the same location as other types of counselling, further protecting client confidentiality. 95% of the clients on treatment maintain ART for six months or longer. Integrating rather than segregating HIV-positive clients helps protect client confidentiality and reduce stigma.[21]

Health Poverty Action, since 2008, has been implementing a maternal and reproductive health programme in Somaliland which integrates HIV/AIDS. The programme links and coordinates with other actors such as Progressio, GFATM, and UNICEF at health centre and referral hospital level so that every client has access to all services in a convenient and affordable way. Thanks to an effective referral system, health centres integrate intra-facility services (such as ante- and post-natal care, family planning, basic emergency obstetric care, HIV/AIDS VCT) and refer clients to Hargeisa Group Hospital for other services such as comprehensive emergency obstetric care, ART, PMTCT and post-exposure prophylaxis. Health Poverty Action produces radio programmes and outreach dramas which integrate messages on prevention of HIV and harmful practices such as female genital cutting. The programme's integrated model has proven to be successful in increasing maternal, reproductive and HIV/AIDS service utilisation and health-seeking behaviour.

Better health infrastructure: The HIV/AIDS response has benefited health infrastructure in that it helped establish new and strengthen existing networks of care, electricity and water supplies and

communication services at clinics and laboratories. For example, in Ethiopia HIV/AIDS funding has contributed to the construction of health posts as well as renovation of existing centres and hospitals.

Strong health financing: Vast resources have been made available for HIV/AIDS over the past decade. In some countries, donor funding for HIV/AIDS was the same or more as the entire national health budget. But during the same period donor funding for other public health programmes, such as infectious disease control, has also been increasing and national governments' spending on public health has doubled in 25 lower-income African countries.[22]. One exception is reproductive health funding which remained constant from 1992 to 2005.[23] HIV/AIDS funding brought more attention and funds into the health sector in general, with many investing in health system strengthening. For example, nearly $640 million in PEPFAR funding was for system strengthening, as well as large amounts of GFATM funding. There is little use in speculating whether more funding would have gone to other areas of health had HIV/AIDS received less funds. The real issue is how best to use limited funding most efficiently.



Impact on human resources: The strong focus of resources on HIV/AIDS has put pressure on health staff to tackle the epidemic, and some critics argue that lucrative HIV/AIDS NGO jobs are causing brain drain of government health workers. However, HIV/AIDS programming has also reduced the number of patients coming with opportunistic infections and kept HIV-infected medical personnel alive to do their jobs. For example, in Malawi, access to ART saved the lives of at least 250 out of 1,022 health care workers in 2007.[24] The spotlight on HIV/AIDS and its need for a large number of staff to roll out VCT and ART has brought attention and resources to the severe health worker shortage in developing countries.[25] For example, in Kenya, the Clinton Foundation, GFATM and PEPFAR now fund the salaries of more than 2,000 additional health workers, after which the government has agreed to take over. Other countries like Ethiopia and Ghana are scaling up community level health worker programmes to tackle both HIV/AIDS and other health needs. World Health Organisation (WHO), PEPFAR and UNAIDS responded to the health worker shortage by developing task-shifting guidelines, which has helped countries to reorganise tasks among health workers and hire non-professional workers. When WHO and the South African Government began integrating HIV/AIDS into the health sector in 2004, there were concerns that this would increase the workload of health staff. But integrated management tools were rolled out with training, ongoing clinical mentoring and supportive supervision. This resulted in health workers feeling more confident to integrate HIV/AIDS services and 2,000 new patients were initiated on ART every month in Eastern Cape Province alone.[26] WHO concluded that this approach works as long as the health system is strong enough to carry the increased workload of delivering the HIV/AIDS services.

Good health information systems: The HIV/AIDS response has encouraged governments to report on targets such as those of the UN General Assembly Special Session (UNGASS) on HIV/AIDS. In some countries, HIV/AIDS resources helped health data collection systems to move from paper-based systems to electronic ones. In others, the HIV/AIDS response has created a practice of public information sharing on health, for example through Demographic and Health Surveys. Despite this, complaints can be heard in several countries about burdensome duplicative reporting processes and monitoring by HIV/AIDS actors and the rest of the health system. Countries are making progress towards having a single national monitoring system to avoid duplication, but many of them have farther to go.

Improved procurements: Stock outs of ART drugs are very serious because of the importance of non-disruption of treatment adherence. Because of this, logistics, supply and procurement systems have received a lot more attention and have been improved as a result of investments in HIV/AIDS. In many countries HIV/AIDS procurement and distribution have been effectively integrated into national

supply systems. The Red Cross argues that the HIV/AIDS universal access agenda has led to strengthened systems for drug pricing and procurement.[27] HIV/AIDS activists have contributed to the wider health rights debate by pointing out injustices around access to ARV drugs. This has increased awareness on the cost of medicines, facilitating access to affordable (generic) medicines in general. One example is the leukaemia drug Glivec where India has set a good example in using trade-related intellectual property rights flexibilities.[28]

Public-private partnership: HIV/AIDS programmes have in some countries promoted public-private partnerships which have expanded to other areas of health. For example, in Ethiopia, private laboratories perform CD4 counts and other HIV tests and are reimbursed by the Ministry of Health. Public agencies have also cooperated with businesses in the HIV/AIDS response, for example in workplace programmes in which business infrastructures and facilities provide HIV/AIDS services to workers and communities and thereby promote better health in the workplace.[29]

Strong leadership, coordination and governance: The global response to the HIV/AIDS pandemic has motivated governments to show strong leadership, governance, collaboration and coordination with the private sector, civil society, and PLHIV groups, for example through GFATM Country Coordinating Mechanisms. Governments lead the national HIV/AIDS response, while donors align to national priorities and strategies in coordination with one another. Previously marginalised groups such as men who have sex with men and sex workers are now involved and consulted. This approach sets a precedence for good governance, coordination and participation in the health sector more widely.

2.2 Lessons learnt from integrated HIV/AIDS and other health initiatives

- There is a lack of systematic studies on integration of HIV/AIDS and health in different countries, using agreed-upon frameworks and measurements. PEPFAR, GFATM and WHO are now working on the basic principles and frameworks to guide future research.
- Integration, if done well, represents excellent value for money compared to vertical programmes.
- As seen in the case of South Africa, integration requires careful initial planning, financing and human resources to ensure its success. It is important to ensure that integrated HIV/AIDS and health services do not overly increase the burden on already overburdened health workers and clinics.
- As is clear from the diverse examples above, there is no formulaic model for HIV/AIDS integration. It must be done based on the context. For example, in conflict or refugee camp settings, it may initially be more feasible to focus on basic services that do not require HIV counselling and testing – such as TB, sexually transmitted infections (STI) and opportunistic infection treatment and condoms.[30] In each context, specific issues and risk populations will need to be addressed at national level – such as identifying, developing or improving protocols for HIV counselling and testing, PMTCT, ART, resolving drug supply issues and ensuring health workers are trained appropriately.
- PLHIV and most vulnerable groups like internally displaced persons, men who have sex with men and sex workers must be considered in efforts for HIV/AIDS integration.
- With adequate health staff training and sensitisation, integration of HIV/AIDS clients into generalised health clinics and services helps protect client confidentiality and reduce stigma

3 HIV/AIDS and Poverty

3.1 The impact of HIV/AIDS programmes on poverty

Labour-saving technologies: HIV/AIDS resources and interventions have led to the development of technical innovations that save labour while improving food security for PLHIV. For example, improved bean varieties have been introduced that give increased yields without increasing time/labour requirements[31]; a new hybrid hoe/pickaxe was invented to make cultivation easier in the dry season;[32] and low-labour gardening techniques have been developed (keyhole gardens, sack gardens, tyre gardens, etc.). While tailored for PLHIV, these ultimately improved food security and livelihoods more widely by their roll-out to whole communities and spontaneous replication.

Small-farm mechanisation: The HIV/AIDS epidemic has reduced labour availability, which has led to HIV/AIDS programmes for small-farm mechanisation and particularly draught animal power which require less human labour. Some of these programmes encourage the use of smaller livestock such as donkeys to encourage women's use of draught animal power. These initiatives go beyond support to PLHIV by improving nutrition and livelihoods for whole communities. They prove to be successful particularly where draught power is customary, or long-term funding is available to introduce it properly.[33]

Conservation agriculture: Conservation agriculture has been introduced in many HIV/AIDS programmes because it reduces time spent on physically demanding preparation and weeding (tasks frequently undertaken by women) and enables other tasks (like harvest) to be spread over a greater period of time, reducing the intensity of labour. It is an environmentally friendly approach that maintains soil fertility and food security through permanent soil cover; minimal soil disturbance by minimising tillage; and crop rotation to recycle nutrients, improve soil and reduce disease and pest damage. Despite substantial start-up investments required, it has proven to improve food security and livelihoods in whole communities and has lower yield fluctuation (i.e. risk) than conventional agriculture.[34]

Nutrition interventions: The response to the HIV/AIDS epidemic has seen a rise of development projects that emphasise nutrition, for example those that introduce untraditional seeds (pumpkins, leafy greens, sweet potato); herb gardens; community or backyard vegetable gardens; nutrition education; cooking groups/demonstrations; and vegetable marketing support. While these were initially developed to improve ART adherence and extend the life of PLHIV, they also benefit the wider community in terms of nutrition, food security and generating income.

CARE's DFID-funded Zimbabwe Protracted Recovery Programme began in 2004. It provides agricultural inputs and training; community and homestead gardens; community seed storage systems; food assistance; community home-based care; irrigation systems; small dams; savings clubs; latrines; water points; and promotes sustainable natural resource harvesting and conservation farming. The project integrates HIV/AIDS with some interventions specifically for HIV/AIDS-affected households while others have inbuilt responsiveness to HIV/AIDS (e.g. food aid is distributed in such a way that people do not need to stay overnight to pick it up). By targeting "the vulnerable" rather than explicitly "PLHIV", HIV/AIDS-affected households benefit without suffering increased stigma. The integrated approach is working. Assessments found that households involved in more than one intervention have greater food security, agricultural yields, livelihood opportunities and assets. Mike Marimira, a participant (see photo), said "before we received help from CARE, most of the time I was bedridden. CARE helped us start a homestead garden, a beehive, a toilet and a savings club. Now we have a honey-producing beehive and a homestead garden from which we get nourishment. We eat some of the vegetables, dry some for later and sell some. When we came out to be openly HIV-positive, others saw we were living positively and receiving support. Now others are coming out."

Livestock introduction: HIV/AIDS projects such as those of Heifer International have been introducing livestock to HIV/AIDS-affected families to improve household nutrition, offer an income opportunity and provide fertiliser for crops and gardens. Zero grazing (keeping a small number of livestock fenced in and carrying food to them) and small livestock schemes (providing goats, chickens, pigs, rabbits, sheep, duck, etc.) are often chosen for HIV/AIDS initiatives because they provide access to milk, meat and manure while requiring little labour and time. The Makondo Health Centre in Masaka district, Uganda, run by the Medical Missionaries of Mary – a local partner of Trocaire – has an integrated HIV/AIDS and livestock programme. They offer antenatal care, VCT, TB testing and treatment, ART and treatment and give small livestock such as chickens, goats and pigs to needy families (including orphans, widows, and the chronically ill) who pass on offspring from their

livestock within an agreed period.[35] These interventions have benefited not only PLHIV but wider household and community livelihoods.

Sustainable natural resources harvesting: These programmes have been piloted to promote PLHIV nutrition. For example, CARE supports honey, dried indigenous vegetables, marula jelly and mopane worms projects; and Health Poverty Action supports Devil's Claw herb production among indigenous San in Namibia. Mozambique Action for Social Development (ADS), a local partner of Trocaire, is promoting the nutritious Moringa tree in Cheringoma district to improve the health of PLHIV, orphans and vulnerable children. Community members who completed the training are now promoting Moringa themselves and PLHIV support groups are using it when they cook communally for their children.[36] Such initiatives benefit both PLHIV and the wider community.

Improved access to water: Many HIV/AIDS programmes include a water and sanitation component given this is a vital need for PLHIV and transporting water for domestic and agricultural use creates a major labour demand. HIV/AIDS programmes that put in place treadle pumps or drip irrigation for example can extend the time period over which crops can be grown (reducing pressure on families who have less capacity to work) and increase the number of harvests in one growing season for the whole community.[37]

Strengthened community cooperation: HIV/AIDS interventions often support the formation of formal and informal labour-sharing groups of people affected by HIV/AIDS. For example, some groups work together to get planting and harvesting done in time. Others graze their cattle together to avoid each family having to herd their animals separately. There are also community seed banks that ensure that farmers have adequate access to a diversity of seeds at the right time of year; Chiefs' Fields where communities produce on a communal field and give the proceeds to those who are most vulnerable; and PLHIV groups who engage in income generation such as artisanal activities. HIV/AIDS programmes have also improved the format of savings and micro-credit groups to make them more sustainable – through internal insurance schemes and encouragement of family members to take over membership. These civil society groups benefit whole communities in terms of food and livelihood security.

Social protection: The HIV/AIDS epidemic has changed demographics, with a rise in orphans, child and elder-headed households and destitute families. The response has been a rise of social protection interventions such as cash transfers and other social safety nets. These have had a significant impact on families affected by HIV/AIDS, as well as on other households. Many social protection schemes wisely target the "chronically ill" and other needy groups rather than exposing HIV/AIDS-affected families.

3.2 Lessons learnt from integrated HIV/AIDS and poverty reduction initiatives

- Research is required over a long period of time to understand how food emergencies in HIV/AIDS-impacted countries are a new or at least different kind of food insecurity as a result of the disease. Labour supply, recovery strategies and commodity markets may have altered.[38]
- Integrated HIV/AIDS and poverty reduction initiatives are needed. The alternative – recurrent food shortages and more frequent famines that merely attract emergency responses – will be more expensive and less effective than integrated initiatives that could prevent them before they occur.
- Integrated HIV/AIDS and poverty reduction programmes must depend on the local context of the epidemic, such as disease prevalence and the dynamics of food insecurity and malnutrition.
- Integrated programmes can have excellent results if they address the specific needs of groups affected differently by HIV/AIDS and AIDS – PLHIV not yet on treatment, PLHIV on ART, HIV-positive pregnant women, HIV-positive mothers, HIV-positive children, marginalised groups, etc.[39]
- The most effective way to mitigate the impact of HIV/AIDS *and* address the effects of extreme poverty is through a holistic combination of: 1) labour-saving technologies/other opportunities (civil society groups, livestock rearing, other sources of income), 2) social protection programmes, and 3) wider provision of ART and other essential HIV/AIDS services. Labour-saving technologies

are effective and social protection programmes provide an important safety net for those who would otherwise go farther down the road to destitution, but neither are a full solution. The only intervention that *truly* solves the labour issue and curbs the HIV/AIDS impact in the long-term is wider provision of ART because ART saves lives and allows people to be economically and socially productive.

4 Overall Recommendations – Principles of effective HIV-programming

4.1 Rethinking HIV/AIDS-programming through integration

As shown above, HIV/AIDS does not respect sectoral or programmatic boundaries. HIV/AIDS services must be integrated into primary health care systems and other relevant sectors. Many synergies already exist between HIV/AIDS programmes and health and poverty initiatives. These should be maximised and policy and technical frameworks generated by these should be developed. HIV/AIDS can be integrated into any sector but it makes sense to focus first on sectors with vulnerability to HIV/AIDS – both in terms of their human resources and the impact HIV/AIDS has in this sector. The initial steps of HIV/AIDS integration can be taken without cost (collecting documentation, early meetings, etc.) or through small pilot activities (such as PROFAMILIA's) but beyond that there must be an understanding of resources available. Specific vulnerable populations such as MSM and IDUs also are good entry points for HIV/AIDS integration particularly where the epidemic is still confined to small marginalised groups. The services should be provided to all free from discrimination and coercion, and should be gender sensitive, accessible, youth and marginalised group-friendly, and financially and physically accessible. (HIV/AIDS and gender links are elaborated in the *Mainstreaming HIV/AIDS in the DFID Strategic Vision for Girls and Women* policy brief). Later the programme can be expanded into an entire sector or the larger population. Addressing vulnerable groups' needs also helps build greater equity in countries' development policies.

Countries or organisations new to HIV/AIDS integration can learn from the information, resources and results of others who have already been successful. UNDP, UNAIDS and experienced NGOs, governments and academic institutions have relevant expertise, technical resources, policy advice and networks to help plan integration. Integrating HIV/AIDS is a process of learning, engagement, action, experimentation and reflection. More research and documentation is needed to monitor changes in sectors as a result of HIV/AIDS, to understand the long-term effects of the epidemic and to design appropriate future policies and interventions. Studies should also track the lessons and successes of HIV/AIDS integration.

4.2 Soft power for measurable effects

Closer and more integrated work on HIV/AIDS is needed between stakeholders at national and international levels from a range of health, wider assistance and protection programmes. Relevant stakeholders and sectors should be involved in the integration process as part of a wider team or AIDS Committee. They may include: UNAIDS, UNDP, World Bank, multi- and bilateral organisations, NGOs, the National AIDS Authority, ministries, civil society organizations, religious leaders and PLHIV organisations.

HIV/AIDS integration requires commitment to long-term institutional transformation that changes norms, values and systems. It requires high-visibility champions and strong leadership, coordination and tracking of outcomes of multiple sectors and actors by a central authority.[40] National AIDS Authorities must take on this role in their countries and, at the international level, this might be under the auspices of UNAIDS or via some other mechanism. These leaders must lobby governments to ensure that Poverty Reduction Strategy Papers and other policy frameworks genuinely support HIV/AIDS integration into other sectors. Integrated health programmes and spending should reflect the actual health burden and social epidemiology within the country. National ministries of health should have the power and ownership to allocate funds as necessary.

4.3 Funding for impact

The most effective way to integrate is through a combination of: 1) labour-saving technologies/other opportunities, 2) social protection programmes, and 3) wider provision of ART and integrated

HIV/health services. The Strategic Investment Framework's cost-benefit analysis shows that this approach presents better value than allowing the HIV/AIDS epidemic to worsen.

Governments and donors should thus continue to increase investment in HIV/AIDS. DFID should maintain its HIV/AIDS funding and (particularly given that its multilateral aid review found GFATM "very high" value for money[41]) use its influence to pressure GFATM to reverse its decision to delay Round 11 funding. At the same time, funding must increase for universal primary health care and poverty reduction. Sustainability should be at the heart of funding objectives: continued commitment is important for HIV/AIDS (where patient survival depends on lifelong access to drugs) but also for long-term investments like health system strengthening. DFID and other donors should commit to funding cycles conducive to integrated approaches of a minimum of 5 years.

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