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Discussion Paper

The Future of AIDS Coordination

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1. CONTEXT

“Effective AIDS responses require strong leadership from inside and outside government, at national and local levels. Governance and oversight structures must be designed to promote accountability, achievement of results, and synergies between HIV and broader health efforts. Inclusion of vulnerable populations and effective partnerships between government and civil society are crucial.”¹

The purpose of this Discussion Paper is to raise contemporary issues that inform policy dialogue regarding the coordination and management of National AIDS Responses. The paper considers current HIV and health policy debates as well as global funding trends, arguing that how countries govern and coordinate their national responses to AIDS will become more important if we are to ensure a more strategic use of resources and continue the progress made in the global response.

In 2011 UNDP conducted a six-country study to document existing models of national coordination of AIDS responses. Six country case studies were produced that provide an overview of the state and functioning of coordination in: Belize, El Salvador, India, Indonesia, Malawi and Tanzania. The country case studies identify good practices, lessons and emerging issues.

The response to the global HIV epidemic has achieved remarkable progress. The rate of new infections has dropped sharply and at the end of 2011 more than 8 million people were accessing life-saving HIV treatment. However, with 7 million people still in need of treatment and 2.5 million people newly infected in 2012, ensuring access to affordable medicines and scaling up prevention programmes remains crucial. Strengthening capacity at the country level to effectively coordinate and manage AIDS responses and to respond to emerging health and development challenges will become ever more central to sustaining and expanding our progress on AIDS.²

While for the first time since the beginning of the epidemic domestic investments in HIV have surpassed international assistance, many countries continue to grapple with the sustainability of AIDS financing.³ Reduced international funding for AIDS and constraints in the current donor environment have put emphasis on greater effectiveness and more efficient use of resources.⁴

This, coupled with the recognition that national HIV programmes need to be more effectively integrated into health and national development plans, has put the effectiveness of national AIDS coordination bodies under greater scrutiny.

In 2011 the UNAIDS Investment Framework argued for a more targeted and strategic approach to investment in the global AIDS response.⁵ The Investment Framework calls on countries to prioritize and implement the most effective HIV interventions through strategic, multi-sectoral responses.⁶ The Framework is fast becoming central to the funding approaches of major donors and underpins the new funding model of the Global Fund To Fight AIDS, Tuberculosis and Malaria (the Global Fund). The Global Fund's funding model ties funding for HIV, tuberculosis (TB) and malaria to national disease strategies and health plans while putting emphasis on stronger national capacity and processes for the identification of country needs and priorities.

1. UNDP, (2012), *Strategy Note: HIV, Health and Development 2012–2013*.

2. PEPFAR, (2012), *BluePrint for an AIDS Free Generation*. Available here: <http://www.pepfar.gov/documents/organization/201386.pdf>

3. UNAIDS, (2012), *World AIDS Day Report: Results*.

4. UNAIDS, (2012), *Report on the Global AIDS Epidemic*.

5. Schwartlander, B., Stover, J., Hallett, T., Atun, R., Avila, C., et al. (2011), *Towards an improved investment approach for an effective response to HIV/AIDS*. *Lancet* 377: 2031–2041.

6. UNAIDS and UNDP, (2012), *Understanding and Acting on Critical Enablers and Development Synergies for Strategic Investments*.

This greater emphasis on national ownership and leadership has important implications for how countries manage and coordinate national AIDS responses. Countries are taking greater control over the management and coordination of the response and are increasingly reviewing their national AIDS architecture.⁷ While national coordination approaches vary from country to country, it is clear that effective coordination will be ever more critical to integrating AIDS into national development agendas and to attracting and optimally managing the resources needed to reach global prevention and treatment targets. More importantly, at a time when a new map of global development is being drawn, with countries and development actors discussing the post-2015 development agenda, there is a need to ensure that HIV interventions and lessons contribute to lasting success for global health and development more broadly.⁸

This Discussion Paper focuses on the following elements of national coordination: **Financing; Coordination Structures; Integration with the Health Sector; Decentralized Coordination; and Participation of civil society and key populations.** Finally, it raises key forward-looking questions that national policy makers and development partners need to consider when reviewing AIDS coordination mechanisms.

2. FINANCING

Global financing for AIDS has increased substantially over the last decade, from \$7 billion in 2004 to \$16.8 billion in 2011,⁹ constituting 30 percent of all development assistance for health worldwide.¹⁰ While this is a significant increase, reaching the agreed global target of US\$22 billion in annual HIV spending by 2015 will require considerable efforts on multiple fronts, including continued investment by international donors, an increase in domestic financing as well as the use of innovative funding mechanisms. At the national level, this necessitates a renewed focus on strengthening the capacity of national coordinating bodies to manage existing and new resources.

Low- and middle-income countries have relied heavily on external financing, leaving them vulnerable to the unpredictability of donor funds and often considerably weakening national ownership.¹¹ Sub-Saharan Africa's dependency on international funding has been especially stark, with over 60 percent of investment coming from external sources.¹² In Tanzania, resources from the Global Fund and the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) together accounted for 86 percent of funding in 2010.¹³ In Indonesia, a middle-income country, the share of domestic financing for AIDS is only around 40 percent. The 2012 UNAIDS Report on the Global Epidemic however shows that countries are heeding the call for greater investment of domestic resources. Despite a difficult economic climate, more than 81 countries have increased domestic investments by 50 percent between 2001 and 2011. In 2011, for the first time, domestic investments from low- and middle-income countries surpassed global giving for HIV. Some countries are leading by example: El Salvador, Botswana and South Africa now cover more than 75 percent of their national HIV responses through domestic sources, while Kenya and Rwanda doubled their domestic HIV spending between 2006 and 2010.¹⁴

7. Dickinson, C. and Druce, N., (2010) , *Perspectives Integrating Country Coordinating Mechanisms with Existing National Health and AIDS Structures: Emerging Issues and Future Directions*.

8. UN System Task Team for the Post 2015, (2012) *Agenda Realizing the Future we want for all: Report to the Secretary General*.

9. UNAIDS, (2012), *World AIDS Day Report: Results*.

10. Institute for Health Metrics and Evaluation, (2013), *Financing Global Health 2012: The End of the Golden Age?*

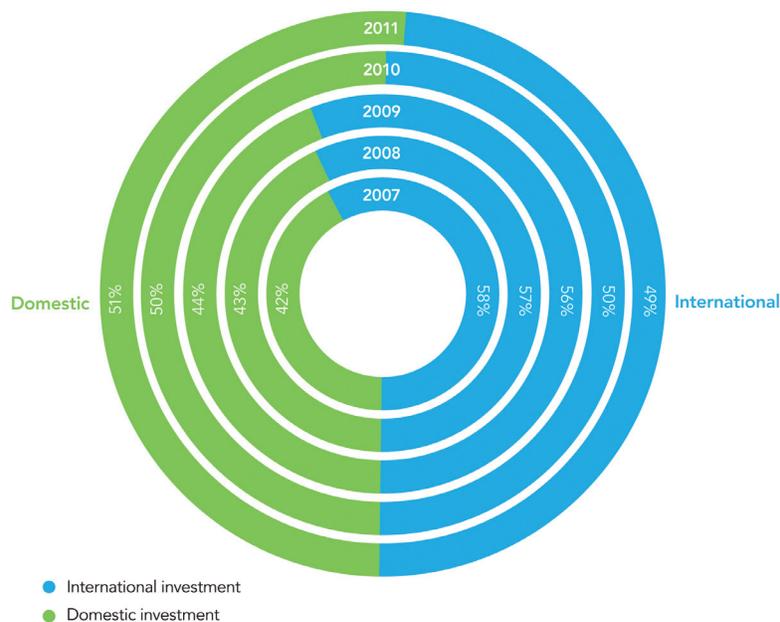
11. UNAIDS, (2011), *AIDS at 30, Nations at the Crossroads*

12. UNAIDS (2012), *AIDS Dependency Crisis, Sourcing African Solutions*.

13. UNDP, (2012), *Tanzania Coordination Country Case Study*. TACAIDS, 2010) *Tanzania Joint National AIDS Funding Assessment*.

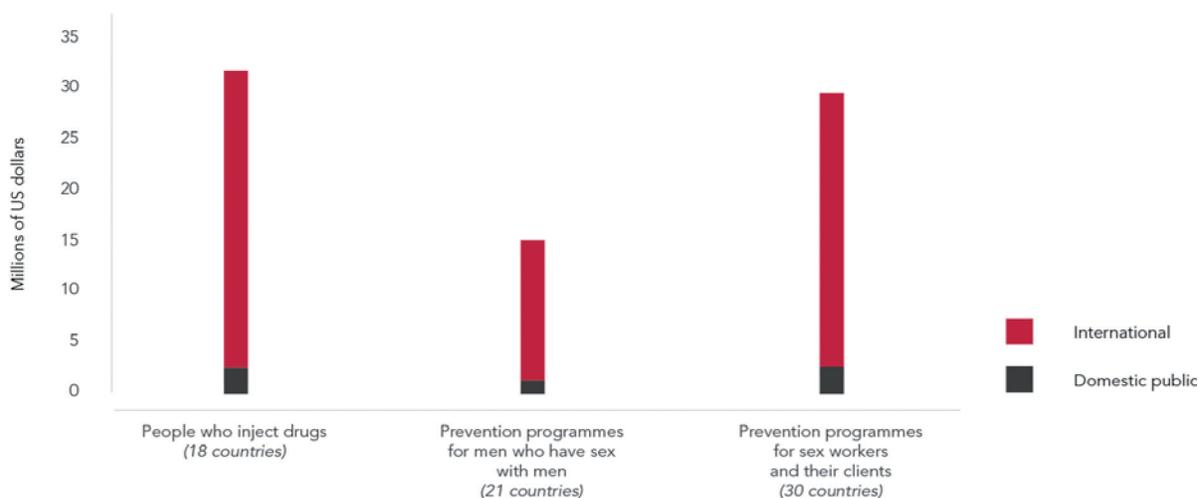
14. UNAIDS, (2012), *Report on the Global AIDS Epidemic*; UNDP, (2012) *National Coordination of AIDS Responses: El Salvador Case Study*.

Resources available for HIV in low- and middle-income countries, 2007–2011



Source: Report on the Global AIDS Epidemic, UNAIDS, 2012

Although countries are increasingly recognizing the need to address HIV among key populations, recent increases in resources for HIV programmes for men who have sex with men, sex workers and injecting drug users have primarily resulted from the efforts of international donors. As domestic funding for AIDS grows, it will be important to ensure an emphasis on rights-based programming. In 2010–2011, for example, international funding accounted for 92 percent of all spending on HIV programmes for men who have sex with men.¹⁵ Similarly, while funding for HIV prevention programmes for sex workers rose 3.7 fold between 2006 and 2011, the majority of this increase and 91 percent of total spending come from international donors. Evidence suggests that these programmes are rarely supported by national resources, especially in countries that criminalize these populations and where there is very little political capital in including them in any national initiative.^{16, 17}



Source: AIDS, health and human rights: Toward the end of AIDS in the Post-2015 Development Era, UNAIDS, 2013

15. UNAIDS, (2012), *World AIDS Day Report: Results*.

16. UNAIDS, (2012), *Report on the Global AIDS Epidemic*.

17. AmfAR and Johns Hopkins Bloomberg School of Public Health, (2012), *Achieving an AIDS-free Generation for Gay Men and Other MSM*. Available at: http://www.amfar.org/uploadedFiles/_amfar.org/In_The_Community/Publications/MSM-GlobalRept2012.pdf

The increase in domestic financing is accompanied by important changes in the funding modalities of some large international donors. The Global Fund's new funding model links funding to the existence of strong national disease strategies and requires broader national consultations as the starting point for applying for financial support.¹⁸ The funding model will permit countries to apply for funding at any time, allowing them to link external funding to their own planning and budgeting cycles. In addition, forthcoming guidance on national strategic planning from UNAIDS calls for a greater focus on implementation, making a case for more strategic national planning processes focused on achieving results.¹⁹ This will require stronger national coordination and inclusive country processes leading to effective country articulation of needs and priorities.

In this context, and with a greater push for spending money on proven interventions, effective coordination and management of resources at the national level becomes ever more important. Experience shows that overarching national donor coordinating bodies can lead to better alignment of resources to national priorities and better value for money in aid. These structures often support open and inclusive planning and costing processes for National AIDS Strategies. In Indonesia an important framework for development cooperation and country ownership is provided by the Jakarta Commitment, an agreement that sets out that the government will assume a stronger leadership role in the design and delivery of official development assistance.²⁰

In Tanzania, the consistent and meaningful involvement of the donor community in designing, assessing and costing national AIDS plans has strengthened aid alignment and donor coordination. Aid management in Tanzania is guided by the Joint Assistance Strategy (JAST), a medium-term framework jointly developed by the government and development partners. Under the JAST, different bilateral donors have signed memoranda of understanding with the government for direct budget support to the current and upcoming National Multi-sectoral Strategic Framework on AIDS (NMSF 2013–2017). These NMSF Grant Agreements cover different aspects of the framework. In 2010, PEPFAR launched a five-year Partnership Framework contributing more than US\$1.65 billion in support of Tanzania's NMSF. All goals in the PEPFAR plan have been aligned with the national strategic framework.

These donor-coordinating structures are considered an important step toward enhancing coordination between national governments and international development partners. They underline the need for effective leadership, ownership, and oversight of the national AIDS response, while reflecting the priorities and approaches favoured by national governments.

The global economic downturn has exposed the unsustainable nature of the present financing model and the dependence of many countries on a small number of international donors, questioning the medium-term sustainability of entire AIDS responses. Globally, UNAIDS estimates that an additional \$2 to \$3 billion is required annually if treatment and prevention needs are to be met.²¹ While high-income countries should continue to invest in the AIDS response, more sustainable and long-term health financing needs to come from innovative sources of funding. At the international level, there is considerable potential in a proposed tax on financial transactions.²² Recently, the High Level Taskforce on Innovative International Financing for Health Systems reviewed more than 100 initiatives and identified an airline tax, tobacco tax, immunization bonds, advance market commitments, and debt swaps as the most promising sources for new and additional financing. UNDESA also argues that financial and currency transaction taxes are "technically feasible and economically sensible" and can present an alternative to meeting global development financing needs.²³

18. The Global Fund, (2012), *Decision Points: 28th Board Meeting*.

19. UNAIDS, (2012), *National HIV Strategies and Implementation for Results: Guidance for 2015 and Beyond*.

20. In 2009, 21 partners – including all major donors – signed the Jakarta Commitment, which redefines the relationships between the Government of Indonesia and its development partners.

21. Institute for Health Metrics and Evaluation, (2013), *Financing Global Health 2012: The End of the Golden Age?*

22. UNDP, (2012), *Innovative Financing for Development: A new model for Development Finance?*

23. UN-DESA Policy Brief, (2012), *The Potential of Financial Transaction Taxes for Development Financing*.

However, despite the number of innovative financing schemes launched for health, most have remained small, with only three reaching global scale (the GAVI Alliance, the Global Fund and UNITAID).²⁴ Nationally, however, some countries are beginning to look for their own solutions. Tanzania launched the Tanzania AIDS Trust Fund as a mechanism for the country to raise domestic resources from new taxation. Kenya and Uganda have recently launched HIV trust funds proposing to generate resources through levies on bank transactions, air tickets, beer, soft drinks and cigarettes, as well taxes on goods and services and taxes on remittances from the two countries' diaspora communities.²⁵ Other countries, like Belize, have begun to experiment, with notable success, with public and private insurance, including national health insurance, and other vehicles to ensure integrated health services. Stronger national AIDS coordination and the meaningful engagement of ministries of finance and planning will be central for countries to truly tap into the potential of innovative financing mechanisms.

While challenges remain in effectively coordinating development assistance and rising domestic investments in AIDS, important progress is being made. In many cases donor-coordinating bodies have ensured better alignment to national priorities. National governments are increasing their own resources on AIDS and many will soon be able to align Global Fund financing to their own planning and budget cycles. To respond to this new funding environment, countries need to strengthen national coordination capacity and ensure that coordination mechanisms are robust enough to anchor AIDS priorities in domestic budgetary discussions and processes.

3. COORDINATION STRUCTURES

Several countries are reviewing their national AIDS architecture, aiming to ensure more efficient and effective operating structures. While some have chosen to merge National AIDS Commissions (NACs) and Global Fund Country Coordinating Mechanisms (CCMs), others are integrating NACs into ministries of health. The options differ from country to country and reflect local realities and needs.

Since the early years of the HIV epidemic, there has been much experimentation and testing of different forms of coordination. Initially, AIDS responses were headed by ministries of health. In the 1990s, with increasing recognition of the multi-sectoral nature and development impact of the epidemic, standalone national AIDS coordinating authorities (NACAs) or programmes (NAPs) were established in many countries.²⁶ In 2004, UNAIDS launched the Three Ones initiative²⁷ aimed at rationalizing action on AIDS under one national action framework, one national coordinating body, and one national monitoring and evaluation system. The establishment of the Global Fund and its nationally-led Country Coordination Mechanisms (CCMs) led to further debates concerning the effectiveness of AIDS coordination structures. To date, several papers and studies have documented the history and functions of national AIDS coordination structures.²⁸

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24. Atun, F., Knaul, F.M., Akachi, Y., Frenk, J. (2012), *Innovative financing for health: what is truly innovative?*, The Lancet Volume 380, Issue 9858, pages 2044–2049.
 25. <http://www.africomnet.org/communication-resources/highlights/1682-kenya-trust-proposes-tax-on-cash-from-diaspora-for-hiv-aids.html> and <http://www.plus-news.org/Report/96443/UGANDA-HIV-trust-fund-in-the-works>
 26. The World Bank, World Bank Multi-country HIV/AIDS Program Eligibility Criteria, available at <http://web.worldbank.org/WBSITE/EXTERNAL/COUNTRIES/AFRICAEXT/EXTAFRHEANUTPOP/EXTAFRREGTOPHIVAIDS/0,,contentMDK:20415735~menuPK:1001234~pagePK:34004173~piPK:34003707~theSitePK:717148,00.html?jumpMenu=%23#EligibilityCriteria>
 27. UNAIDS, (2004), *The Three Ones: Key Principles*.
 28. See, for example, Dickinson, C. (2005), *National AIDS Coordinating Authorities: A synthesis of lessons learned and taking learning forward*. London: HLSP, E. Serleimitsos, J. Mundy, C. Dickinson and J. Whitelaw-Jones (2009) *A synthesis of institutional arrangement of twelve National AIDS Councils in sub-Saharan Africa.*, STARZ and Spicer et al. (2010), National and sub-national HIV/AIDS coordination: are global health initiatives closing the gap between intent and practice? *Globalization and Health* 6(3) <http://www.globalizationandhealth.com/content/6/1/3>; and Morah E. and Ihalainen M., (2009), *National AIDS Commissions in Africa: Performance and Emerging Challenges*, *Development Policy Review*, 2009, 27 (2): 185–214.

Within the global AIDS community, there is a growing understanding that governance structures should not be prescribed at the international level, but should respond to country contexts while preserving key principles of good governance, including: the engagement of sectors outside of health, alignment of donors to national priorities, effective and targeted decentralization, and the inclusion of civil society, women's groups and key populations.

Over the last ten years, CCMs have been credited with expanding the participation of civil society in the governance of HIV responses. However, CCMs have also introduced an additional governance structure at the national level.²⁹ Recently, more and more countries are looking to integrate NACs and CCMs to streamline governance structures and avoid costly duplication.³⁰ Belize, for example, has fully merged its NAC and CCM. The merged structure has helped in bringing down transaction costs and widening representation of civil society on the NAC while aiding the preparation of targeted grant applications to the Global Fund.³¹ In Tanzania, the government replaced the CCM with the Tanzania National Coordinating Mechanism (TNCM). The TNCM was given the expanded role of coordinating all international resources for HIV, TB and malaria. The TNCM now provides a forum for sharing information amongst all stakeholders and has enabled development partners to minimize duplication and reinforce areas of synergy with improved information sharing.

In Malawi, the NAC collaborates with domestic and international partners through the Malawi Partnership Forum (MPF). The MPF, inclusive of national stakeholders, supports implementation of the National HIV Action Framework and serves as an advisory body to the NAC Board. The MPF meets twice a year to facilitate an effective evidence-based response and efficient resource mobilization³² as well as a biannual review of the Integrated HIV/AIDS Work Plan. The Malawi Partnership Forum is a strong example of stakeholders coming together to provide strategic guidance to the government on implementing the AIDS response.

Evidence shows that such reforms have helped to create an enabling environment for cooperation and strategic analysis while minimizing the complexities associated with coordinating a comprehensive nationally-owned response.³³ The new Global Fund Strategy 2012–2016, states that future funding will be closely tied to a country's "national strategic plan and should be guided by existing investment or disease-specific frameworks." NACs, as the owners of national strategic plans will thus have a key role in overseeing Global Fund grant applications and setting priorities. This may provide incentives to the future positioning of CCMs within existing national coordination bodies to ensure a closer working relationship between NACs and CCMs.

Experience shows that countries are starting to adapt their AIDS coordination mechanisms to better suit local complexities rather than conform to a standard architecture. Irrespective of structures, effective coordination arises when various institutions (line ministries, NACs, CCMs, donors and civil society) have clearly defined mandates, work efficiently together, and are sensible for the specific country and political context in which they function. The outcome of good coordination should always be that the contributions of different actors are aligned with the priorities of the national AIDS response. National coordinating structures should facilitate such alignment and collaboration.

29. For a more detailed discussion see Dickinson C. and Druce N. (2010) *Perspectives Integrating Country Coordinating Mechanisms with Existing National Health and AIDS Structures: Emerging Issues and Future Directions*.

30. Dickinson, C. and Druce, N., (2010) *Perspectives Integrating Country Coordinating Mechanisms with Existing National Health and AIDS Structures: Emerging Issues and Future Directions*.

31. UNDP, (2012), *National AIDS Coordination: Belize Case Study*.

32. UNDP, (2012), *National AIDS Coordination: Malawi Case Study*.

33. UNDP, (2012), *National AIDS Coordination: Tanzania, Malawi and Belize Case Studies*.

4. INTEGRATION WITH THE HEALTH SECTOR

Vertical AIDS programmes have resulted in significant progress and have proven that countries are able to design and implement multi-sectoral national responses taking into account the crucial role of sectors beyond health. However, they have also highlighted great disparities in health systems and an inefficient and duplicative use of resources.³⁴

Successful HIV responses combine strong health services with strategic action in other sectors to address the underlying socio-economic factors that influence the epidemic – these include income and gender inequality, access to education, migration patterns, and inadequate protection of human rights.³⁵

Since the 1990s, there has been widespread recognition that an effective response to HIV requires a broad response that goes beyond the health sector.³⁶ Engaging sectors other than health, however, has had mixed success across a variety of countries. Approaches such as integrating AIDS priorities into poverty reduction strategy papers (PRSPs) or national development plans have not necessarily cemented multi-sector responses. The evaluation of the UNDP, World Bank and UNAIDS Secretariat joint programme on integrating HIV into PRSPs showed that there is still considerable lack of alignment between national AIDS strategies and national development plans.³⁷

Current trends in adapting AIDS coordination mechanisms show a move towards (re)integrating AIDS structures into sector ministries, particularly ministries of health. Rwanda is often cited as a successful example of integrating HIV into the health sector while maintaining multi-sectoral and civil society engagement. Among the six UNDP study countries, India has made considerable progress in integrating HIV structures within the overall health care system. Counselling and testing centres are already part of primary health care and specific services such as treatment and prevention of mother-to-child transmission are being integrated at the state and district levels. However, a proposal from the Planning Commission to merge the National AIDS Control Organization (NACO) with the flagship National Rural Health Mission within the Ministry of Health has raised concerns among stakeholders. While most believe that future sustainability of the AIDS response is partly tied to successful programmatic integration, it is clear that such integration will be extremely complex. In the case of India, the primary health care system is already understaffed and overburdened and may not be able to respond to National AIDS Plan priorities. There are also concerns that services for key populations and human-rights-based interventions, which are still in need of strengthening, will be harder to integrate and will require sensitization of health workers to the needs of people living with HIV, women and key populations.

The shift towards sector ministries and especially health ministries is also part of the African Union Roadmap,³⁸ that proposes African-owned solutions in strengthening sustainable responses to AIDS, tuberculosis and malaria and is structured around three strategic pillars—health governance, diversified financing and access to medicines. The Roadmap tasks ministries of health and finance, rather than NACs, with the responsibility to lead a strategic investment approach and develop a ‘coherent national investment case for HIV.’

Recent guidance from UNDP and UNAIDS on investment approaches reiterates the importance of ‘multi-sectoral and whole-of-government responses.’ The HIV sector has a responsibility to help national development partners understand how their contributions can support successful national AIDS responses.³⁹ As countries are considering integrating AIDS coordination structures within ministries of health, the following considerations must be addressed:

34. Piot, P., Dybul, M. and Frenk, J., (2012), *Reshaping Global Health*. Policy Review 173.

35. UNDP, (2012), *Strategy Note: HIV, Health and Development 2012–2013*.

36. The World Bank, World Bank Multi-country HIV/AIDS Program Eligibility Criteria, available at <http://web.worldbank.org/WBSITE/EXTERNAL/COUNTRIES/AFRICAEXT/EXTAFRHEANUTPOP/EXTAFRREGTOPHIVAIDS/0>

37. Joint Programme on Integrating AIDS into PRSPs: A Review of Experiences, (2008), UNDP.

38. African Union, (2012), *Roadmap on Shared Responsibility and Global Solidarity for the AIDS, TB and Malaria Response in Africa*.

39. UNAIDS and UNDP, (2012), *Understanding and Acting on Critical enablers and Development Synergies for Strategic Investments*.

- Maintaining the multi-sectoral nature of AIDS responses and ensuring appropriate participation of people living with HIV, women and key populations
- Ensuring that the public health system has the capacity to meaningfully absorb HIV services
- Aligning AIDS programmes with other public sector institutions and considering integration of HIV into broader development programmes
- Ensuring that the progress made in delivering non-stigmatized AIDS services and that the rights of people living with HIV, women and key populations are safeguarded and expanded

5. DECENTRALIZED COORDINATION

Effective AIDS responses require a strong partnership between local governments and civil society, with the full involvement of people living with HIV, women and key populations. As the service delivery arm of the state, local governments need to ensure that the AIDS response is well integrated into local development plans and coordinate community level processes.

In most countries, NACs have established structures at the sub-national level to assist coordination at the local level.⁴⁰ These are typically state, district or local AIDS committees with mandates to coordinate implementation of AIDS activities. Experiences from the six UNDP study countries suggest that, while leadership is often strong at national levels, capacity is much weaker at local levels.

The Fourth High Level Forum on Aid Effectiveness in Busan in 2011 stressed the critical role that local governments play in connecting citizens with government and ensuring ownership of countries' development agendas.⁴¹ In many countries, municipal authorities have autonomy in setting policies and administering local health and social services as well as policing. In this context, municipal governments are often the drivers of innovations and are particularly well placed to lead, mobilize and coordinate more inclusive and tailored local responses to HIV. As the level of government closest to communities, local governments can significantly improve the response to the HIV epidemic.

Recognizing the importance of decentralized AIDS responses, countries are continuing efforts to build local leadership. In Malawi, all the 28 districts have assigned District AIDS Coordinators who are integrated within local government.⁴² However, there are a number of issues in formulating and implementing development plans. Even though AIDS district implementation plans exist, they are not well integrated with local development plans and budget processes. These challenges with decentralization are, however, not unique to the AIDS response. The generally slow pace of decentralization in Malawi is said to be prevalent across different sectors.

India has been successful at driving decentralization and creating functioning structures at the state and district levels that are relatively independent and able to exercise quality control over local responses. State AIDS Control Societies (SACS) have been created in all federal states. The SACS are expected to assume a central leadership role and coordinate the work of all partners in each state. In a few states, SACS have been merged into an overarching State Health Society. There is close cooperation between NACO at the national level and the SACS, as well as strict oversight by NACO over planning and execution of state AIDS activities. Naturally, not all SACS operate at the same level of efficiency throughout India. According to the majority of national stakeholders, however, SACS are stronger in states with higher HIV prevalence.⁴³ In these states, NACO has created ownership at the local level, where plans are now written and managed by District AIDS Prevention and Control Units and local stakeholders.

40. UNDP, (2012), *National AIDS Coordination Case Studies: Tanzania, Malawi, Belize, El Salvador, Indonesia, India*.

41. OECD, (2011), 4th High Level Forum on Aid Effectiveness, Busan Partnership Agreement.

42. UNDP, (2012), *National AIDS Coordination Case Study: Malawi*.

43. UNDP, (2012), *National AIDS Coordination Country Case Study*.

While the nature and scope of sub-national AIDS responses depend on national decentralization policies, even with limited authority, local governments can potentially achieve gains in coordinating AIDS action at the local level, mainstreaming HIV into existing work plans, and working closely with local partners to ensure greater access to prevention, treatment and care services.

Recently, UNDP has supported the Government of Côte d'Ivoire in undertaking a review of the functioning of decentralized AIDS structures following the merger of the Ministry of AIDS with the Ministry of Health. The review highlighted that, when AIDS coordination structures are integrated within sector ministries, the roles and responsibilities of existing decentralized structures at the regional and district levels need to be clarified to avoid confusion and disruption in service delivery.

As efforts are underway to strengthen local AIDS responses, bolstering local governance capacity in regions with a high burden of HIV – that is strategic decentralization based on epidemic burden – remains critical. Particular attention should be paid to building partnerships that are central to the development of successful local AIDS plans that are linked to broader development processes at the local level. This should lead to partnerships among local authorities, civil society organizations, people living with HIV, women's groups and key populations groups to strengthen implementation of local AIDS responses.

6. CIVIL SOCIETY PARTICIPATION

Civil society organizations have been at the forefront of responding to HIV from the early days of the epidemic. The leadership by people living with and affected by HIV has been instrumental in driving comprehensive responses to the epidemic at global, national and local levels. In most countries, civil society organizations remain at the forefront of prevention, care and support programmes, particularly among women and the most vulnerable and hard-to-reach populations.

In many countries civil society organizations (CSOs) are fully integrated as active participants and contributors in the coordination of national AIDS responses. CSOs are often part of national planning and policy processes. Within a resource-constrained environment, however, governments are making tough choices. Community organizations feel increasingly constrained not only in accessing resources but also in having a say in how diminishing AIDS funding is spent.⁴⁴ CSOs across all regions are reporting a decline in funding over the last two years, with established, long-standing organizations being the hardest hit. To cope, most CSOs have scaled back on staffing and key programmes, especially human-rights based or community mobilization initiatives.⁴⁵ A recent assessment of funding for civil society in Malawi, Swaziland and Zimbabwe⁴⁶ shows that, with the cancellation of Global Fund Round 11, countries are redirecting resources from CSO activities towards treatment, HIV testing and PMTCT initiatives. There is growing concern that this will considerably weaken the community structures built up over the last three decades.

With a transition to domestic financing of AIDS programmes, attention needs to be paid to the impact of government-led and -funded responses on civil society activities and activism, their independence and the overall representation of key populations. While networks of people living with HIV and AIDS service organisations have been included in national coordination mechanisms, the representation of women and key populations remains highly inadequate.⁴⁷ In Malawi, for instance, while women are particularly vulnerable to HIV infection and gender inequality plays a crucial role in the epidemic, women's interests are institutionally underrepresented, with no organization specifically representing women's issues and interests on the NAC. The same is true for other key population groups such as men who have sex with men and sex workers. Multiple and diverse channels of financial support, especially at the local and decentralized levels, are more likely to aid civil society groups.

44. Edstrom, J. and MacGregor, H., (2010), *The Pipers Call the Tunes in Global Aid for AIDS: The Global Financial Architecture for HIV Funding as Seen by Local Stakeholders in Kenya, Malawi and Zambia*.

45. Open Society Initiative for Southern Africa, (2012), *The First to Go: How Communities Are Being Affected by the Global Fund Crisis*.

46. OSISA, (2012), *Less Global Funds, More Problems*. Available at <http://www.osisa.org/hiv-and-aids/regional/less-global-funds-more-problems>

47. UNDP, (2012), *National AIDS Coordination Country Case Study: India* and UNDP, (2012) *National Coordination Case Study: Malawi*.

The six UNDP study countries showed that fundamental challenges remain in realizing the full potential of civil society engagement in the national AIDS response. The first issue is representation and capacity-building. It is true that civil society is generally involved in policy and planning activities through, for example, representation on NAC Boards, CCMs or in the planning processes for National HIV Strategies. However, most CSOs assert that, while they have a seat at the table, they need strengthened capacity to fully participate and be involved at the decision-making level ('meaningful representation'). Consistently, CSOs across the six study countries stress that a particularly lacking area is the ability to engage in constituency dialogue and feedback. This holds especially true for CSOs that are members of CCMs, as they represent not a single organization, but a much larger constituency.⁴⁸

Over the past thirty years, the AIDS movement, mostly through relentless efforts by CSOs and people living with HIV, has been challenging pre-existing notions of participation in the governance of health issues. Leadership by people living with and affected by HIV has been instrumental in driving comprehensive responses to the epidemic at the global, national and local levels. In order to support transparent identification of national priorities and future resource allocations, countries will need to strengthen the involvement of people living with HIV, women and key populations.

7. LOOKING FORWARD: KEY QUESTIONS

Over the past few years, countries have come up with different coordination arrangements to suit their political, social and economic contexts. Coordination mechanisms are generally inclusive of key stakeholders and responsible for planning and coordinating resource allocations. As UNAIDS continues to support countries to use strategic and enhanced investment approaches in HIV, the capacity of AIDS coordination bodies to coordinate input from ministries of health, planning and finance becomes ever more important. Similarly, the new funding model of the Global Fund calls for country-owned dialogues to prioritize high-impact, evidence-based interventions for Global Fund resources. The funding model requires CCMs to organize enhanced country dialogues to identify national disease priorities in a transparent and inclusive manner. This calls on countries to broaden the participation of civil society, women and key populations in particular. In fact, while CCMs have played a positive role in the inclusion of civil society and people living with HIV within national AIDS processes, in most countries this has not been extended to representatives of key populations.

These UNAIDS and Global Fund initiatives represent a unique opportunity for countries to streamline coordination mechanisms, strengthen multi-sectoral coordination and broaden the participation of civil society and key populations in particular.

Looking forward, the Post-2015 development agenda is expected to embody a call for a new vision and approach that measures development in terms of well-being, health, security, and quality of life. As the structures governing the AIDS response become increasingly country-owned and responsive to country contexts, authentic country ownership needs to be manifested in political leadership, active communities and local voices. A people-centred approach to development that addresses people's opportunities and needs in a holistic way and gives priority to the engagement of communities in decision-making, including women, young people, marginalized groups and key populations at higher risk, will deliver more sustainable progress.

The AIDS response has established an innovative approach to health governance through its principles of inclusion, accountability, shared responsibility and global solidarity. To continue to build on the successes of the past 30 years the following key questions need to be considered:

- Are national coordinating bodies well placed and do they have the authority to coordinate the HIV work of all key government sectors?
- With increasing domestic resources for national AIDS programmes, how can rights-based programming be protected to ensure that the progress made in delivering non-stigmatized AIDS services to key populations is safeguarded?

48. UNDP, (2012), *National AIDS Coordination: Indonesia, India and Malawi country case studies*.

- When integrating AIDS structures under ministries of health, how can effective multi-sectoral engagement be maintained?
- How can countries use donor-coordinating bodies to strengthen aid effectiveness as well as donor alignment to national priorities?
- How can the capacity of sub-national government be strengthened to ensure better integration of AIDS action into community development at the local level?
- How will countries retain and expand the participation of CSOs, people living with HIV, women and key populations to become fully empowered, equal partners involved in all aspects of HIV responses at national and sub-national levels?

For more information: <http://www.undp.org/content/undp/en/home/ourwork/hiv-aids/overview.html>

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