Global Financial Architecture of the Aids Responses
Plenary session – Session Room 1
Tuesday, August 5
12.45 – 16.00

Honourable Ministers, ladies and gentlemen,

I am pleased to have an opportunity to give my perspectives on the topic of this afternoon's discussion, the Global Financial Architecture of the AIDS response.

In 2006 global leaders made a commitment to achieve universal access to HIV prevention, treatment, care and support by 2010. This commitment represents an exciting level of ambition and hope, but also poses formidable challenges to all of us. Each one of us represented in this panel - implementing country governments, donors, financing institutions and global normative agencies – is grappling with difficult questions that will be the topics of this afternoon's discussion. How can we make sure that scaling up HIV services contributes to health systems strengthening, rather than detracting from it? How can we ensure that resources, domestic and international, are spent effectively? How do we sustain funding for life-long treatment when we know that resource needs will increase dramatically over the coming years? And how can we collectively better support national efforts to fight HIV/AIDS and limit transaction costs to developing country governments?

I want to focus my intervention on two critical areas. Firstly I want to speak about the level of funding and the way funds are used. Secondly I will reflect on linkages between HIV/AIDS and the broader health and development issues.

Funding for HIV/AIDS has increased twenty-fold over the last decade to an estimated USD 10 billion in 2007. This is unprecedented in international development and we owe that to the unwavering efforts of many advocates around the world. Is it enough? Not nearly so. UNAIDS estimates that funding levels must **quadruple** between 2007 and 2010 to achieve universal access.
We welcome the political resolve in the United States to renew its global AIDS program and to significantly increase the resources that will be made available. We would like to see similar resolve in other major economies of this world. A recent study by UNAIDS and the Kaiser Foundation listed my country, the Netherlands, as the number one per-capita donor on HIV/AIDS, and the third international donor in absolute terms, after the United States and the United Kingdom. Whilst I am proud to be the number one per-capita donor, I have mixed feelings about being the third largest donor internationally. Should I consider this an achievement of a relatively small economy? Or is it rather a sign of

underachievement of all those other countries with economies that are far larger than ours? I tend to the latter interpretation.

Are we spending our money effectively? The latest UNAIDS report that was released last week contains some encouraging news. Three million people in low and middle income countries are now on treatment and the numbers of deaths due to AIDS are slowly declining. More HIV-positive pregnant women receive antiretrovirals to prevent the transmission to their children. HIV prevention efforts are beginning to show success in some countries and we see encouraging signs of sexual behaviour change among young people. These are welcome indications that funding has produced results and impact. We can, and must, however do much more to increase our effectiveness. We must look harder to reach the people who do not have access to treatment. These are disproportionally the disadvantaged and marginalised groups in our societies. We must massively scale up prevention efforts and address the real drivers of the epidemic. "Know your epidemic" should the basis for evidence based planning with no room for ostrich tactics and denial. Power dynamics and the poor position of women and girls increase their vulnerability for infection. We must do much more to empower women and respect their sexual and reproductive health and rights. We must do much more to protect the rights of marginalised groups such as injecting drugs users, sex workers and sexual minorities and increase their access to effective interventions. Last week's edition of Science contained a rather disturbing figure on prevention expenditures on men having sex with men in Latin American countries with highly concentrated epidemics in this group.

With some positive exceptions – Mexico and Peru in particular – the overall picture was grim and illustrates the overt bias against sexual minorities in many countries in this region.

Are we spending our money equitably? Last week's Science clearly demonstrated we are not. Whilst a number of well-organised countries have been successful in securing significant commitments from donors, others have not. Rwanda has received over USD 2000 per infected person while this amount is lower than USD 150 for countries such as the Democratic Republic of Congo, Central African Republic, Sudan and Myanmar. Corrupt governments, civil wars and the absence of infrastructure scare away donors. There are no simple solutions to this and yet we know that any global response to AIDS must address the impact of the epidemic in fragile states. This is a collective responsibility and one where each and every one of us must be prepared to take risk.

Secondly I want to share some reflections on the need to improve linkages between the AIDS response and the broader health and development agenda. It is evident that better integration is needed to achieve and to sustain universal access. We must combine the incredible energy and activism of the AIDS community with the long-term

approaches to sustainable and equitable development. For too long this debate has been polarised in a very unhelpful way. I also believe that the onus for integration has too often been put with the AIDS community whereas the health and development community has a responsibility too. Integration requires all of us to move to a middle ground and I am convinced that there is so much that we can learn from each other.

Over the last few years there has been a particularly heated ideological debate on health systems versus HIV/AIDS. Speeches during the opening session and during yesterday's meetings indicated that there is a great openness in the AIDS community to have these discussions. We know that there are real issues in some countries. A recent public expenditure review in Tanzania pointed to the distortive effects of targeted HIV funding on health systems. But there is also a growing body of evidence of countries that have managed to use targeted funding to achieve disease specific outcomes **and** broader systems benefits at the same time by investing in key areas such as human resources and infrastructure. Rwanda and Ethiopia are countries that come to mind. We should learn from these experiences and work towards pragmatic solutions. We simply can not afford competing over scarce resources. The sad reality is that health systems have been underfunded for decades and HIV is certainly a long way off being considered overfunded. We must demystify what we mean by health systems and clarify what needs to be done to meet people's needs and legitimate expectations when it comes to health care. Primary health care might be a good binding framework to integrate these different elements. In any case, solutions will need to be country specific. As international agencies – donors, multilateral agencies and financing institutions – we have a moral obligation to support countries in these efforts. I would be interested to hear from panellists how they see their role in this regard.

Apart from funding, the AIDS response has introduced important paradigm shifts that are of great relevance to the health sector, and development more broadly. One important shift is the notion that access to care and treatment is a right, not a charity. Another one is the recognition of the crucial role of civil society organisations as advocates, as watch dogs and as service providers. If we manage to integrate this thinking into our approaches to health systems strengthening we can make a giant leap towards the development of responsive health systems that deliver results that matter to people.

Sustaining universal access over the long term requires better integration of HIV/AIDS in the broader development agenda. Unfortunately these obvious linkages are often poorly developed. In many cases the AIDS response happens quite in parallel from broader development efforts. In too many countries HIV/AIDS is still not well integrated into poverty reduction strategies and Medium Term Expenditure Frameworks. Moreover these instruments are rather exclusively focused on the public sector. One could say that many of the traditional aid instruments are not sufficiently AIDS proof. This can have

huge implications, even more so as many bilateral donors are moving towards upstream funding modalities such as direct budget support. At the same time most of the AIDS funding is delivered through different channels such as PEPFAR, the Global Fund or the World Bank MAP. I see a serious risk for an increasing and persistent disconnect between the two efforts. So whilst there is a compelling case for linkage there is as yet little evidence on how that should be done. Again this requires all of us to rethink the way we are doing business.

It requires the main AIDS funding agencies to improve their behaviour as far as harmonisation and alignment is concerned. But is also requires a much more thorough discussion on how HIV/AIDS, and other cross-cutting issues such as gender for that matter, are really part of our traditional aid instruments. And on the potential negative spill-over of the implementation of the Paris declaration, if important development issues are not adequately addressed in the tools that we use. Again I am very much looking forward to hear the panellists view on this.

We have a panel of highly distinguished speakers that represent different elements of the global architecture for HIV/AIDS. We have an audience that is brimming over with energy, creativity and passion. I am very much looking forward to a lively debate between all those participants.

Thank you for your attention.