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Parliamentary Briefing on HIV/AIDS: parliamentarians as partners in the fight against HIV.

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Introduction

In spite of continuous long-term interventions to control the HIV epidemic, HIV prevalence is high and still rising in many parts of the world. Twenty years ago, the AIDS patient was a white, homosexual man, in his thirties, mid-class and living in the US or Europe; now the face of the epidemic is black, female, young and poor. Since 1991, 65 million people have been infected with the virus. Nowadays, over 33 million people are HIV infected, with 2.5 new infections and 2.1 million who died of AIDS in 2007. For every person put on ARV treatment in 2007, another 4 people became newly infected.

Main achievements since the 2006 UNGASS review on HIV/AIDS

1. More and better data are known on the epidemiology of HIV/AIDS, indicating regional priorities and interventions.
2. Preventive methods are available, mainly abstinence, behaviour changes and condoms, but more work is needed to guarantee accessibility and availability of preventative measures including condoms. Female controlled methods are lacking.
3. Mortality has decreased where ARV are available, and over 3 million people in DC are now on antiretroviral therapy. Still millions of people are not aware of their HIV status and lack access to treatment.
4. Research on microbicides and vaccines has had several setbacks over the last years, but new promising molecules are in the pipeline.

5. The AIDS epidemic has lead to a discussion on how to coordinate efforts and funding of health systems in a rapidly changing world with competing health priorities.

What needs to be done?

An integrated, sustainable and comprehensive response to the epidemic is needed, including 1) roll out and scaling up proven and locally adapted prevention strategies, 2) expanded access to treatment and care, 3) increased research efforts into female controlled methods such as barrier methods and microbicides, as well as into vaccines, 4) operational research on determinants of successful interventions, 5) fight against ignorance, stigma, discrimination and human rights violations, 6) a better coordination of health programmes and a shift of paradigm of health planning and expenditures (towards a global health insurance system), based on access to health care as a universal human right.

Special attention is needed for:

1. The *dynamics of the HIV pandemic*. The HIV epidemic is linked to core groups in the industrialized word and has a predominant heterosexual dynamic in Africa. Specific, locally adapted answers are required. Focusing on key populations such as sex workers, men having sex with men, and IDU's is urgently needed in the west as in developing countries, whereas policies and programs empowering women need strengthening in many developing countries. *Think globally and act locally*!
2. *Prevention* needs renewed attention, and barriers to proven prevention methods have to be banned (eg obligation to stress that condoms are ' only' 98% effective in many programmes, limited access to condoms and FP methods for youngsters, unmarried women etc…). All individuals should have unlimited access to proven methods such as condoms and condoms should be mentioned in all prevention programmes next to abstinence and behaviour changes.
3. *Access to treatment* has to be accelerated; over 3 million HIV infected people have access to ARV treatment which is a tremendous step forward, but upto 10 million still need medication.

4. *Linking Sexual and Reproductive Health and HIV*, on the policy as well as on the programmatic and structural level. The final political declaration of 2006 highlighted policy and programmatic linkages, and opportunities for integration have been elaborated such as VCT, PMTCT, STI prevention and management, and ARV. Yet, many cultural, societal, religious and gender inequalities remain increasing women's vulnerability to HIV/AIDS.
5. PMTCT *(prevention of mother-to-child transmission of HIV*) programmes have to be rolled out, but primary prevention is also needed in the reproductive age group.
6. *Research and development* needs more support. In particular, as women often lack the socio-economic empowerment to demand condom use, female controlled methods such as microbicides and cervical barrier methods provide interesting and hopeful perspectives when condom use is low due to social, cultural and/or economic factors. However, microbicide development and mainstreaming face many challenges. Viable, high quality research projects require affordable and manageable study designs, high levels of participation and large budgets to carry out the research programmes. Given the magnitude of the epidemic, these challenges have to be faced in the run to find adequate preventive female controlled methods to protect women (and men) from the HIV virus.
7. AIDS treatment cannot be provided in isolation from *health systems*. A vertical approach works for a while, until it hits the ceiling of insufficient health workers and dysfunctional health systems, particularly in countries with high HIV prevalence. Hence, there are growing calls for greater programme integration between priority diseases initiatives and underlying health care delivery.
8. Against this background, it seems logical to argue that foreign assistance should support a *diagonal approach*, rather than a purely vertical or purely horizontal approach. In practice, strident advocacy for purely vertical or horizontal approaches may result in destructive competition for resources of the kind exemplified by claims that: "HIV is receiving relatively too much money, with much of it used inefficiently and sometimes counterproductively." Instead of competing, diagonal funding would follow the new realities of AIDS programming, which is becoming increasingly diagonal both in terms of

integration and coordination with other disease programmes, such as sexual and reproductive health, with maternal and child health.

9. The conventional approach to *health system development* is that foreign assistance should make itself redundant. Sooner or later recipient countries must be able to finance health services with their own resources. The Global Fund for AIDS, Malaria and Tuberculosis has abandoned this conventional approach, in favour of a new form of sustainability that relies on a combination of domestic resources and predictable, open-ended foreign assistance. This paradigm shift was essential, and should extend beyond priority disease programmes focused on AIDS, tuberculosis and malaria. Donor failure on this point is one reason that general health services remain catastrophically under-funded. The model of the Global Fund can be used to work towards an expanded health workforce, to argue for broader measures of health system strengthening, and to support the integration of health services. Several initiatives are being discussed to consolidate towards a global health fund with one health sector funding channel.

What can Parlementarians do?

1. Show leadership, leadership, leadership!
2. Face the realities of the HIV epidemic and other health problems and fight stigma, discrimination, homophobia and violations of human rights in their countries.
3. Assess the legislation in their own countries and change laws that are hampering HIV prevention and access to care, or violating human rights such as travel restrictions, laws prohibiting sex before marriage or homosexual relations, lack of laws to penalize gender based violence.
4. In the view of growing feminization of the HIV epidemic, ensure that women are key partners in the fight against HIV/AIDS and well represented in all for a.
5. Review the resolutions adopted by the United Nations General Assembly of the 2006 High-Level Meeting on AIDS and examine the progress globally and within their own country/region.
6. Review the resolution adopted by the UN General Assemblee in January 2008.

7. Review and discuss the Manila declaration of the IPU meeting on HIV/AIDS in 2007 and order the Handbook for parliamentarians ' **TAKING ACTION AGAINST HIV'.** Jointly produced by IPU, UNDP and UNAIDS, this Handbook is both a call to action for parliamentary leadership and a reference book to which parliamentarians and their staff may turn for information and guidance on specific issues of importance in the response to HIV. It provides many illustrations of good practices by legislatures and gives examples of leadership by individual parliamentarians. The Handbook is designed to help parliaments and their members to exercise fully their legislative, budgetary and oversight powers to tackle HIV in their communities and countries.
8. Propose the organisers of the International AIDS conferences to provide a track for political leaders and parliamentarians to facilitate the dialogue between politicians, scientists, communities, action groups and private sector, and to increase the political responsibility and visibility.
9. Call upon their governments to prioritize HIV/AIDS in those countries where it is epidemic, and call upon the donor community to continue support for HIV/AIDS in an integrated way, in a diagonal structure of health care support based on access to health care as a basic human right.
10. Demand insight in foreign aid revenues that are often not known or acknowledged in government expenditure reports and accounts
11. Actively participate in the upcoming discussions and challenges of health care financing in the era of HIV/AIDS, aiming for better donor coordination and interaction between donor and recipient countries.
12. Listen to the research communities in their countries and call upon them to form a partnership in future planning of policies, and in setting the research agenda.
13. Listen to NGO's, community action groups and others for better planning and parliamentary actions.
14. Support multilateral, bilateral and global collaborative efforts. *Think globally and act locally.*
