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**XVIth International AIDS Conference
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***TIME TO DELIVER
PASSONS AUX ACTES***



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List of abbreviations

MSM	Men having Sex with Men
OVC	Orphans and Vulnerable Children
IDUs	Injecting Drug Users
CSWs	Commercial Sex Workers
UNAIDS	The Joint United Nations Programme on HIV/AIDS
M + E	Monitoring and Evaluation
GFATM	Global Fund to fight AIDS, Tuberculosis and Malaria
HEARD	Health Economics and HIV/AIDS Research Division
WHO	World Health Organisation
PREP	Pre-exposure chemoprophylaxis
AB	Abstinence, Be faithful
PMTCT	Prevention of Mother to Child Transmission
ARVs	Antiretroviral drugs
HAART	Highly Active Anti-Retroviral Therapy
VCT	Voluntary Counselling and Testing
TB	Tuberculosis
STIs	Sexually transmitted infections
TTR	Treat, Train, Retain
DFiD	Department for International Development
ART	Antiretroviral Treatment
UK	United Kingdom

Executive summary

The 16th International AIDS Conference in August 2006 was attended by 24'000 delegates, international celebrities but few political leaders only. Its agenda lacked focus, ignored to a large extent the African continent and did not succeed in uniting the various stakeholder groups around common solutions. Some of the essential information shared during the conference:

Policy and advocacy

- Keep visibility and exceptionality of AIDS high, but at core of development agenda
- Needs shifting from short term emergency to long term systemic response
- More accountability in keeping the promises made is key to getting funds to the ground
- Global health agenda increasingly driven by celebrities
- Positive assessment of GFATM

Epidemiology

- Today we are 25 years into the epidemic
- End of 2005 there were 38.6 million people living with HIV or AIDS - the incidence peaked in the 1990s but the number of PLWHA continues to rise
- Recent declines in certain national HIV prevalence rates
- Particular focus needed on women, children/youth, MSM and IDUs

Prevention

- Shift from treatment to prevention
- Spotlight: New preventive commodities: microbicides, male circumcision, PREP (pre-exposure prophylaxis), HIV vaccines
- AB/abstinence only controversy
- Prevention of paediatric HIV is a top priority

Scaling up ART

- Goal: Universal access by 2010
- 1.6 million people in resource limited countries under ART
- 21 countries met 3by5 goals
- Global coverage only 20% (children SSA~5%, paediatric challenges)
- HAART as prevention
- Controversy routine opt out testing versus VCT

Health Systems and Human Resources for Health

- Are the single biggest obstacles to universal access
- Decentralised delivery model involving nurses seen as the future
- How to overcome vicious cycle of ART further weakening health systems
- Good practice examples exist from Namibia, Haiti, Malawi and South Africa
- WHO TREAT, TRAIN, RETAIN (TTR) initiative to address shortage of human resources
- « Open the purses for nurses » - more funding for human resource sector needed
- Development partners (DFID, Clinton foundation) innovative strategies to fight the brain drain

Introduction

The AIDS response is still suffering from an imbalance of rhetoric and ideology over action and evidence.

2006 was the third time Canada hosted an international AIDS conference. The opening ceremony of the conference, attended by some 24'000 delegates, reflected a strong feeling that we are at a time where there are more resources allocated to the fight against AIDS, there is more scientific evidence and stronger political commitment than ever before- yet, rhetoric and ideology are still prevailing over action and evidence. "History will judge us not by scientific advances but by what we do with our scientific advances:" (Anthony Fauci, American immunologist). While several thousands of scientific papers were presented and hundreds of scientific sessions took place during this one week long conference, more than 50'000 people died of AIDS.

Painfully, the prevailing lack of political commitment and leadership was reflected by the much criticised absence of the Canadian Prime Minister, Steven Harper, from the opening ceremony which led to the withdrawal of the Liberian president in consequence. International personalities that supported the calls of the conference organisers by attending the conference included Bill and Melinda Gates, Bill Clinton and Richard Gere.

Policy and advocacy- stock taking; where are we heading

The AIDS epidemic needs an exceptional response, at the core of the development agenda.

As Peter Piot, executive director of UNAIDS, stressed, it would be wishful thinking to believe that we shall be able to stop the AIDS epidemic in this generation. HIV and AIDS will have a devastating effect for decades to come. This means that AIDS needs an exceptional response. For an effective future fight, he outlined **six top priorities**:

- Keep the visibility and exceptionality of AIDS high, but at the core of the development agenda
- Ensure long-term, sustainable and continued funding of all credible AIDS plans
- We must make money work for the people on the ground, invest in systems and communities, particularly the most vulnerable ones (including MSM, IDUs, CSWs and OVCs)
- Accelerate and sustain research in microbicides and other preventive tools
- Efficiently address the social drivers of the epidemic, which are most importantly the low status of women, homophobia and lack of respect of human rights alongside with inequities and racism.
- All actors should unite- in order to win against the epidemic, we should not spend energy in fighting each other over ideological divides.

Main social drivers that need to be addressed are low status of women, homophobia, human rights and inequities.

It was also stressed, that we need to move from a short term emergency to a long term systemic response, based on "the 3 ones" (one agreed HIV/AIDS action framework that provides the basis for coordinating the work of all partners; one national AIDS coordinating authority, with a broad based multi-sector mandate; and one agreed country-level monitoring and evaluation system).

Throughout the conference the crucial role of local governments in the

We need to move from a short term emergency to a long term systemic response.

AIDS response was stressed. Local governments have a stronger power to mobilise and empower communities and should engage in partnerships around the world. Since they are per definition multisectoral they are also well placed to be important players in the local AIDS response. They should be involved in all steps from planning, over implementation to M&E.

According to UNAIDS estimates, US\$ 8.9 billion will be available in 2006 to combat AIDS in low and middle-income countries, increasing to 10 billion in 2010. This is still far short of what would be needed (15 billion in 2006 and 30 billion in 2010). More accountability in keeping the promises made and long-term commitments are seen to be major priorities. Getting the funds which are actually disbursed to the ground where they are needed is the other major challenge. It is therefore not a simple formula "where more money means more delivery" (Prof. Whiteside from HEARD of the University of Kwazulu Natal, South Africa).

Also, global health policy is more and more driven by celebrities rather than heads of governments and public health experts. Celebrities have an important role to play in advocacy and can mobilise important financial resources. The achievements of the Bill&Melinda Gates- and the Clinton Foundation are impressive and were widely applauded. However, private foundations cannot substitute a global response of the international community which is driven by priority setting, rational resource allocation and equity concerns.

The GFATM is seen as the best way to channel funds and is much appreciated also by civil society.

The role of the **Global Fund to Fight AIDS, TB and Malaria** (GFATM) was praised almost unanimously. There was strong appreciation of the GFATM's role from the side of civil society representatives. The positive assessment was based on the experience that the fund offers untied money, respects principles of activists, is a learning organisation which is responsive to the feedback of civil society and serves as a model for other sectors as a possible financing mechanism. Remaining challenges and weaknesses were highlighted as follows:

- The timeframes given are too short to achieve the performance required- the process is perceived as a short term approach to very long term problems which does not take account of the complex and challenging realities.
- There is a lot of confusion around the flow of funds at the level of the country coordinating mechanisms.
- It is felt that some of the Local Fund Agents in charge of the auditing (mentioned: Mc Kinsey) don't know enough about how things work at the country level - the notion that the private sector is the most efficient should be challenged.

The vision was raised by Richard Feachem that most of the international funds should in future flow through one single harmonised financing mechanism, that would not have a role in implementation or delivery and be based on principles such as performance, accountability and transparency. This mechanism could- but does not need to- be the GFATM. The GFATM already since funding round 5 does invest in health system strengthening linked to the delivery of the three big disease challenges. It was realised that it would be important that the World Bank comes on board of the strengthening health systems agenda. This, however, could not happen without "reengineering" of the Bank. A global platform for

health systems would be needed. The US representative strongly challenged the “one funding mechanism” idea and called for one house with many rooms, where there would be better collaboration based on the Monterrey Consensus. One agreed problem was also the recognition that for the moment “the three ones” are “talk” at the policy level, but not really put into practice at the country level - neither by governments, nor by development partners. Patience seems to run out at the country level - many felt that what we need is not new strategies and commitments, but rather **“let’s just do what we promised to do, with speed, quality and accountability”** as a Ministry of Health delegate from Ethiopia stated.

Epidemiology

25 years into the epidemic, 38.6 million people live with the virus.

Numbers of people living with HIV continue to rise.

25 years into the epidemic there were still 4,1 million new infections and close to 3 million deaths due to AIDS in 2005. Southern Africa remains the most affected region in the world with one third of all global cases, while the former Soviet Union countries continue to have the fastest growing epidemic.

An estimated 38.6 million (33.4-46.0 million) people worldwide were living with HIV at the end of 2005. Overall, the incidence rates (new infections) are believed to have peaked in the late 1990s and to have stabilised subsequently, even though some countries continue to experience an increasing incidence. Among the notable new trends are the recent declines in national HIV prevalence rates in two Sub Saharan African countries (Kenya and Zimbabwe), urban areas of Burkina Faso, and similarly in Haiti and the Caribbean. The numbers of people living with HIV have continued to rise due to population growth and due to the life saving effect of anti-retroviral therapy. South Africa’s epidemic, the country with the largest number of HIV infected persons worldwide, shows no evidence of decline.

In Asia, HIV prevalence has also been declining in four states of India and continues to decline in Cambodia and Thailand. Of big concern is the increase in highly populated countries such as China or Indonesia and the signs of HIV outbreaks in Bangladesh and Pakistan.

Much of this information originates from the 2006 UNAIDS Report on the global AIDS epidemic where more details on the epidemiological developments can be obtained.

http://www.unaids.org/en/HIV_data/2006GlobalReport/default.asp

Most neglected groups are: women, children and young people, intravenous drug users and men having sex

Two main groups with particular vulnerability were highlighted during the conference with needs that are still largely ignored in low income countries: Intravenous Drug Users (IDUs) and Men having Sex with Men (MSM). The two other most neglected groups remain women and youth/children, which – regrettably - did not receive a lot of attention, even at the conference.

Intravenous Drug Users accounted for 30% of all new HIV infections outside Sub Saharan Africa and pose a particular problem in Eastern Europe and Asia, where harm reduction interventions are still missing in most national strategies and discrimination against this population is of major concern. Notably, in 2005 two main drugs needed for heroin substitution therapy were added to the WHO essential drugs list. Harm reduction programmes, which belong to the most cost effective HIV interventions, should include education, needle and syringe exchange, sub-

with men.

stitution programmes, health care and community development components. While there is finally a consensus around and clear evidence for harm reduction, opposition against such programmes is still strong from the United States, the country with the highest HIV incidence in the industrialised world. Today, the need for harm reduction programmes is highest and most pressing in the Middle East and Northern Africa.

For the first time, the issue of **Men having Sex with Men** was openly discussed in relation to low and middle income countries at this conference. While it is known that Sex between men is the most prominent mode of HIV transmission in nearly all Latin American countries and is an important driver of the epidemic in Eastern European and many Asian countries, the issue is increasingly also being addressed in relation to Sub Saharan Africa. It is today known that sex between men occurs in every culture and society, though its extent and public acknowledgement vary from place to place. In Sub Saharan Africa the taboo and discrimination against MSM is greatest. Encouragingly, first studies are now available from Senegal and elsewhere documenting the related challenges. UNAIDS has issued a policy brief: HIV and Sex between men¹, which stresses the need to end denial and stigma and calls for urgent actions at all levels.

Prevention

During this conference, a visible shift took place in terms of engagement with HIV - from treatment to prevention (*Picard A.*). While strong efforts to scale up ART need to go on, the international community is realising that unless new infections can effectively be curbed, the situation risks to deteriorate despite progress in improving access to treatment and care. Scaling up effective prevention strategies and investing in innovation to find new preventive tools is therefore at the top of the agenda.

Focus on new preventive technologies: mainly microbicides, male circumcision, PREP and vaccines.

The current “hot issues” regarding **new preventive tools** are listed below. Most advanced and bearing hope for the short term future are:

- **Microbicides** (topical substances, such as gels or creams that could be applied to the vagina or rectum to reduce HIV transmission): No microbicide is on the market yet. Today 5 compounds are in advanced trials. Results from some of these trials could be available by 2008.
- **Male circumcision**: A first 2005 trial showed a 60% protective effectiveness of male circumcision as compared to those men, who had not undergone the intervention. Three additional late stage trials are now underway in Africa to assess the applicability of the South African findings to other settings and populations and to investigate, whether male circumcision also has an effect on reducing HIV transmission to female partners of the circumcised men. Results are expected in 2007. Male circumcision is not yet a recommended preventive strategy. A concern is that circumcised men could wrongly feel protected and stop using condoms or other safe sex precautions. First evidence, however, shows no such effect. The challenges would be huge when introducing such a strategy in contexts where the prac-

1

http://data.unaids.org/pub/BriefingNote/2006/20060801_Policy_Brief_MSM_en.pdf#search=%22UNAIDS%20policy%20brief%20HIV%20and%20sex%20between%20men%22

tice is not a cultural or religious tradition - much controversial discussions were held around this issue during the conference and anthropologists and social scientists uttered their concern about medicalising and decontextualising the practice.

- **Oral preventive drugs-pre-exposure prophylaxis with antiretrovirals (PREP)**: The potential of antiretroviral drugs to be used in a preventive way is being explored. Results could be available as early as 2007 or 2008. Major open questions remain the potential of creating resistance, the potential for abuse and the ignorance about the level of adherence required for protection.

Still further away:

- **HIV vaccines**: remains the best long term hope- however, developing a vaccine is proving to be a scientific super challenge. Most experts predict that it **could be 10 years or more** before an HIV vaccine candidate is shown to be effective. There was critique from scientists, that current approaches are using traditional strategies “more of the same” and that new ways of thinking are needed. It may be that a vaccine will not be able to prevent infection, but reduce the harm caused by the virus. One strong current hope is to develop a therapeutic vaccine to prevent severe or ultimate complications in those infected and reduce long term treatment needs.

Trend of focusing on medical preventive tools and “simple solutions” to a very complex problem.

Several speakers called for putting the **power to prevent HIV into the hands of women**. This means empowering women and working towards reduced gender inequities. But it also means investing in research and development of preventive tools, which women can control. Many of the new HIV prevention methods in development could be particularly beneficial for women, especially in contexts where obtaining social or economic power to refuse sex or negotiate condom use is still a major problem. However, none of these preventive tools will ever solve the problem on its own. Their equitable distribution and access to these tools would need to be addressed. This conference focused on prevention at the level of individuals and their risk behaviour as well as new tools and technologies for prevention. The need to also address social and cultural vulnerability as well as structural factors - on which decision makers could have influence more easily - was always briefly highlighted but not addressed in sufficient details as to “how to”. A disturbing trend of focusing on medical technology prevention and simple solutions to a very complex problem prevailed. People working at the field level felt frustrated as such trends can undermine the realities of local responses and deviate the much needed attention and resources for addressing complex issues such as culture, social norms, behaviours, stigma, poverty, gender and education that will pose barriers to the introduction of such preventive tools, even when they should be available.

Ideological debate over abstinence and condoms continues.

Existing preventive technologies- such as the good and old “condom” and the “femidom” were getting little limelight at the conference, since they are too value loaded. Throughout the conference there was a lot of criticism voiced against the US driven AB or “abstinence only” approach. As Melinda Gates stated that *“if you oppose the distribution of condoms, something else is more important to you than the fight against AIDS. Condoms do not promote earlier sexual activities, but blocking young people from using them does promote unsafe sexual activities.”* It is diffi-

cult to understand, “*why health agencies and programmes still base their prevention messages on the outdated and scientifically corrupt idea of abstinence. Abstinence alone is simply incompatible with most African cultures*”. This strategy risks fuelling the African epidemic by deepening stigma and taboos around sexuality and HIV. (*Horton, Lancet*)

Another much neglected but available and efficient preventive strategy is the **prevention of paediatric HIV** (usually called prevention of mother to child transmission - PMTCT). According to WHO, in SubSaharan Africa only 6% of pregnant women have access to this prevention strategy, which can, together with some other strategies, almost entirely prevent the transmission of the virus to the newborn. The great majority of the 2.3 million children living with HIV in 2005 acquired their infection in utero, during birth or while being breastfed. There is also a new initiative to introduce the new terminology “prevention of paediatric HIV” or “vertical transmission” to stop blaming the mothers.

Treatment and Care

Today, there is no more discussion around whether bringing antiretroviral therapy to low income countries is feasible. The discussions now focus on how to scale up the current levels of coverage and how to make achievements sustainable, within health systems.

The achievements are remarkable in bringing antiretroviral drugs (ARVs) to low income countries. Between 2001 and 2005 the number of people on ARVs in these countries increased from 240'000 to approximately 1.6 million and the number of sites providing these treatments multiplied tenfold within one year (2004-2005). 21 countries have actually succeeded in meeting the “3by5” goals of providing treatment to at least half of those who need it. However, globally, ARVs still reach only one in five who need it, and the situation is even worse in Sub Saharan Africa. It is still true that 90% of the drugs are in the North of the World, while 90% of the patients in need are in the South. There are recent studies which have, however, shown that the adherence of African patients is equal if not better than that of patients in the Americas (*Mills et al, Jama 2006*).

At the conference, it was stressed that HAART (highly active antiretroviral therapy) has also a preventive effect. HAART was seen to contribute to lowering HIV incidence in contexts where risk behaviour remained unchanged. However, this should not lead to the old debate of prevention versus treatment but rather be seen as an argument in defending the cost effectiveness of HAART. There are hypothetical models, that if the world could provide universal access to ARVs by 2050, the epidemic could be controlled - this is still to be interpreted with a lot of caution.

A major concern in providing ARVs still lies with children. Only some 5% of children in need of ARVs do actually get them. **Children** have higher viral loads and higher case fatality rates than adults - also, because there is still a crucial lack of paediatric formula which would be safe and affordable. Currently, there are 600'000 children in Sub Saharan Africa in need of HAART and 1.9 million in need of cotrimoxazole prophylaxis. In that region more than half of the infected infants die before the age of 2 years. The problem can only be solved in addressing both the issues related to the child and their mothers/parents. Vertical transmission causes 90% of all infections of children under 15 years of age. The risk of death

Over 4 years, the number of people on ARVs in resource limited countries increased to 1.6 million.

Many unresolved problems remain for paediatric ART.

for children (both the infected and the uninfected) is halved if the mother stays alive. Children's needs are not properly addressed neither in ART nor VCT services.²

Other priorities are the scaling up of cheap interventions such as the prophylaxis with Cotrimoxazole (better known by the brand name Bactrim) in those infected and to address issues around household food security.

During the G8 meeting in 2005 a call for "**Universal Access by 2010**" was made. During the Toronto conference the following pillars, amongst others, were considered to be essential for universal access:

- Expansion of testing and counselling
- Scale up of treatment and care by providing a minimal package of care for all diagnosed with HIV - e.g. TB screening, Cotrimoxazole prophylaxis, etc) and initiating ARV treatment as soon as possible when medically indicated.
- Strengthening of health systems
- Abolish user fees at the point of care

HIV Testing and Counselling:

During the conference, there was heated debate about routine testing for HIV. Since 2004 Botswana practices "opt out" routine testing (anybody not objecting will automatically get tested). Different from the VCT approach, routine testing puts hardly any emphasis on pretest counseling, since its priority aim is to increase the number of people who undergo testing. Those in favor argued that opt out testing was one of the few practical ways to expand treatment. Opponents feel strongly that this approach undermines human rights principles, particularly in contexts, where there is a power hierarchy between the caregiver and the patient (can the patient take a free decision) and HIV is strongly linked with stigma (is the patient ready to face the impact of knowing about the status). The speakers agreed that routine testing is conditional on universal access to ART, which is not given for most developing countries.

The ongoing debate about the best testing model reminds of the debate around the feasibility of ARVs in developing countries not long ago. Ethical questions around the hierarchy of rights are central in the debate, as well as questions of stigma and discrimination and of vulnerabilities of marginalised communities and social groups. If you live in a high prevalence context, is the right to know (and getting treatment earlier) stronger than the right not to know?

Heated debate around opt-out versus VCT testing approaches.

Health Systems

Single biggest obstacle to universal access is ART delivery model and weak performance of health systems.

The single biggest obstacle to universal access is today the delivery model of ART and performance of health care systems.

Some encouraging experiences from the country level were presented during the conference. In Haiti, ARV was scaled up through integration into the Primary Health Care system. This approach was effective in strengthening health systems and reducing stigma. In Costa Rica, universal access was achieved after a court case which voted in favour of the persons living with HIV/AIDS. In Malawi, ARVs are available in 60 sites with close to 40'000 patients enrolled by the end of 2005. Malawi aims at simplifying the delivery mechanisms through involving nurses and

² see for more details: handbook of pediatric AIDS in Africa
<http://www.fhi.org/en/HIVAIDS/pub/guide/mans1.htm>

**Decentralised
ARV delivery
involving
nurses is the
most promising
strategy.**

medical assistants.

South Africa reported having enrolled 143'000 patients in the public sector and another 100'000 in the private sector (192 treatment sites), which adds to some 25% coverage. The South African presenter was convinced that a hospital based delivery model cannot obtain more than 25% coverage. In a context where ARVs are available, most of the HIV care is "routine" primary health care for a chronic disease. South African Provinces, such as Western Cape or Gauteng, where much higher coverage (60%) was obtained relied on a community health system to deliver the ARVs. In several African countries, the future in scaling up ARV treatment is seen in the decentralised delivery at primary care level involving nurses. This approach also facilitates the integration with other services, such as TB, Antenatal and PMTCT care. Namibia has developed "integrated communicable disease clinics, including ARV, in all public hospitals (34 sites in 2006). Such models needs protocol changes, intense training of health staff and a functioning down-referral and up-referral system for patients. In addition, they rely on strong political leadership and strategic management, good collaboration and increased funding by both the government and development partners. A performing M&E system and investments in infrastructure, laboratory and pharmaceutical services are other components for success.

Equinet (*Daniel Mc Coy*) pointed out 4 tensions when moving towards a health systems approach:

1. expansion of ART versus improvement of other essential health services
2. top down/vertical approach versus an integrated/bottom up approach
3. short term ambitions versus long term sustainable solutions
4. Global Health Initiatives versus National Ministries of Health

The challenge is to overcome the vicious cycle, where ART coverage is achieved at the expense of the other health services, to a virtuous cycle, where ART programmes strengthen health systems. We need to develop indicators of impact on other services (e.g. HIV prevention, TB treatment completion, treatment of curable STIs, infant and perinatal mortality rates, growth monitoring, immunisation coverage, etc) and on the health system at large (e.g. health care equity, internal brain drain, political coherence and crowding out, parallelism/duplication) that help us to know whether a country is in the vicious or virtuous cycle and whether trends are moving in the right direction. Changes in management should also be monitored, including sources, levels and allocation of health care funding, governance and regulations. Interesting reflections around "a health systems development agenda for developing countries" produced by the Global Health Watch can be downloaded from www.ghwatch.org.

Human resources for health

It is today undisputed, that one of the biggest barriers to scaling up HIV prevention, ARV coverage (has shown to directly depend on the density of health care workers) and comprehensive treatment and support lies in the severe shortage of health workers in low and middle income countries. This is why WHO launched in August 2006 a new coordinated global effort addressing this challenge: **TREAT, TRAIN, RETAIN (TTR)**

WHO launched new initiative, TTR, to address burning issue of lack of human resources needed for better ART coverage.

will address both the causes and effects of HIV and AIDS for health workers. For Botswana, for example, it is projected, that between 1999 and 2010 40% of the health workforce will die of AIDS, if no action is taken. Globally, there is a shortage of 2.4 million doctors, nurses and midwives - most critical is the situation in Sub Saharan Africa and some Asian countries. Only a balance between *recruitment, distribution and attrition* can offset the burning health workforce crisis.

TREAT stands for a package of HIV treatment, prevention, care and support services for health workers, who may be infected or affected by HIV or AIDS. *TRAIN* aims at empowering health workers to deliver universal access to HIV services, including pre - service and in -service training for a public health approach. *RETAIN* are most crucial strategies to enable public-health systems to retain workers, including financial and other incentives, occupational health and safety and other measures to improve the workplace as well as initiatives to reduce the migration of health care workers.³

Some interesting practical experiences were presented at the conference. There was a strong call for structural changes at the level of health systems and increased budget allocations to the health workforce to maximise the use of nurses and community based health workers - "*open the purses for nurses*". Relying on a system based on volunteers is not seen as a sustainable and fair way forward. Options are explored in Uganda, Zambia and Rwanda in short term training (3 months) of high school graduates to "HIV medics" who have basic skills in counselling and monitoring patients - the problem of this approach is that it is so far a parallel system and not part of the national health system. Zimbabwe introduced a curriculum for Primary Care nurses with only 18 months of training (half of the normal curriculum) and stronger community focus to cope with the brain drain. The latter can serve the local needs but are not competitive on the international market. Problems of all these approaches are that a system of substandard care is introduced! Advantages and risks need to be closely monitored.

A very interesting development comes from Kenya where there is a surplus of trained nurses that cannot be employed by the government. The **Clinton foundation** will employ 1000 of them to stop the brain drain with the promise of the government to later take them up into the national payroll. The foundation has a policy to employ staff from the private sector and the African Diaspora to avoid pulling staff away from the public sector. Another initiative with similar aims is supported by UK Department for International Development (**DFID**) in **Malawi**. All health workers staying in the country will be granted a 52% salary increase, covered by DFID, and will receive additional training. As a first step in Britain's pledge to increase aid to Africa in 2005 the UK Government announced a six year £100m programme of support to the health service in Malawi. DFID will help provide free antiretroviral treatment for more people living with HIV from next year on, will fund measures to reduce mother and child deaths and invest in better training and higher salaries for doctors, nurses and other health workers. To help fill the current level of vacancies, the programme will also fund volunteer doctors and nurses who will start arriving in 6 months to fill critical posts. The programme will increase

Development partners come up with innovative strategies to offset brain drain.

³ for more details see: WHO 2006 Taking stock: health worker shortages and the response to AIDS http://www.who.int/hiv/toronto2006/TTR2_eng.pdf#search=%22WHO%202006%20Taking%20stock%3A%20health%20worker%20shortages%20and%20the%20response%20to%20AIDS%22-

the UK's spending in Malawi by 50 per cent and will result in a 30 per cent rise in Malawi's total health budget. DFID will pool its funds with the World Bank and Norway to support the budget of Malawi's Ministry of Health.⁴ This is a very interesting development, since for many years so-called "topping up" payments to public health staff by donors have been a taboo issue.

Conclusions

Many attendants of the conference criticised the conference agenda to be unfocused and largely ignoring Africa. Too often non - Africans were speaking on behalf of Africa. At the same time, the South African government was rightly blamed for its lack of leadership and its sometimes unscientific strategies which contribute more to confusion than progress.

The Toronto conference left many public health experts with a concern about the emerging commodity focus. While access to affordable and safe preventable tools can make an important contribution to fighting HIV and AIDS we all know that the epidemic is not caused by a lack of commodities and that the lack of women's empowerment will not be solved by giving them access to commodities. There is no simple solution in the form of "magic bullets" to this very complex problem. Long term sustainable efforts to develop and strengthen health systems are equally important as addressing the social and cultural vulnerability factors which continue driving the epidemic.

In view of the next International AIDS Conference, which is planned for 2008 to be held in Mexico City, there is hope for a more balanced approach between the "well heeled" (scientific, funding, medical, technical experts) at the global level and the "barefoot" (social and community representatives) (*source: the Communication Initiative*). We should not allow ideological debate drive public health policies and funding priorities but should find ways of working together more efficiently in a complementary and interdisciplinary way to "find meeting points of dialogue and partnership" (*Horton*). The current divide into parallel and mutually exclusive conference tracks (biology, medicine, epidemiology, social science and policy making) was not favouring new alliances around joint identification of solutions and strategies. Horton, the Lancet editor, who published a most recommended 3 page editorial on the conference "A prescription for AIDS 2006-2010", came up with the interesting idea that the coming conference in Mexico should identify priority countries and devote specific sessions to each country. All stakeholders from these countries could join forces in mapping, evaluating and planning the country's response to AIDS. The biennial conferences could then serve as accountability instruments to chart success and identify catalysts of change or obstacles underlying failure. (*Horton R, the Lancet , Vol 368 August 26,2006*)

⁴ <http://www.dfid.gov.uk/News/files/pressreleases/pr-malawi-health-full.asp>