

A woman with short, curly hair and a striped shirt is looking at a document with a young girl. The girl is holding a pen and looking at the document. The background is a wooden structure, possibly a ladder or scaffolding, with a red light overlay on the left side.

Sustaining Effective Leadership to Secure Gains, Bridge Disparities and Expedite Progress

A position paper on the leadership role of national AIDS coordinating authorities in the future of HIV prevention, sustainable health and preventing future pandemics

Prepared by the HIV Leadership Forum, a Community of Practice of National AIDS Coordinating Authorities Director Generals of Member States of the Global HIV Prevention Coalition

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The achievements of the global AIDS Community were driven by a confluence of inter-connected factors that are as relevant today as ever including: activism and the engagement of civil society and community, political leadership, multisectoral partnerships and multisectoral collaboration, a response grounded in scientific evidence and innovation; human rights instruments, a step change in financing from millions to billions of dollars and a global and local monitoring system. Many of these factors are now prominent in other Global Health Initiatives, including those aimed at improving women’s and children’s health and are relevant to many other development priorities. Therefore, the lessons are important opportunities, not only for a reinvigorated HIV response, but wider global health communities.

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- The UNAIDS-Lancet Commission on Advancing Global Health, Lancet, July 2015

"These lessons are as important today as they were then."

- Peter Piot, London School of Hygiene and Tropical Medicine



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FOREWORD

The global HIV response has made remarkable progress in the past two decades. The number of people acquiring HIV has been reduced by half and the number of people dying of AIDS-related causes has been cut by two thirds since 2002. Despite the impressive progress, an estimated 1.3 million people globally acquired HIV in 2022 and over 9 million of the 39 million people living with HIV were not receiving HIV treatment. On closer examination, HIV responses are performing unevenly, with significant variations between places and populations. Vulnerable and key populations are especially affected by disparities in access to HIV services, tools and support.



National AIDS Coordinating Authorities (NACAs) were established to consolidate national HIV responses by providing strategic leadership and coordinating multisectoral (or multi-ministerial) and multi-stakeholder activities. Reducing the rapid increases in new HIV infections and AIDS-related deaths were the priorities. NACAs have gained important experience in leveraging the multisectoral infrastructure built around the HIV response for broader public health responses. This is reflected in their expanded mandates which increasingly also include sexually transmitted infections, tuberculosis, health education and demand creation, community engagement, and resource mobilization and allocation for public health. This amplified role became especially visible during the COVID-19 pandemic. Inspired by these experiences, NACA directors-general established a community of practice in 2019, the HIV Multisector Leadership Forum, to strengthen peer-exchange and accountability for progress, cross-country support and collective voice in the global health agenda.

NACA directors-general have taken note of the evolving HIV response landscape and global context, such as disparities between countries and populations' access to health care and other crucial services (highlighted by COVID-19); a global push for integrated models; and the ongoing need for enabling legal and policy environments. Other challenges include; chronic care costs, pandemic preparedness needs, a focus on Universal Health Coverage, and climate change imperatives. These factors are expected to limit the financial resources available for HIV the response; HIV prevention is particularly vulnerable to such funding constraints.

This paper reflects on the history of the HIV response and the experiences of NACAs in the HIV (and, recently, COVID-19) responses in order to plot a path forward in the current operating environment. It makes a powerful case for sustaining effective leadership of NACAs to secure gains, bridge disparities and expedite progress for the HIV response, broader health and in preparing for pandemics.

Dr. Ruth Laibon-Masha,
Chair, HIV Multisector Leadership Forum

EXECUTIVE SUMMARY

The global HIV response has made remarkable progress in the past two decades. The number of people acquiring HIV has been reduced by half and the number of people dying of AIDS-related causes has been cut by two thirds since 2002. In parts of southern Africa, a fall in life expectancy has been reversed. Across the world, widening access to life-saving antiretroviral therapy (ART) is enabling people living with HIV to live long, healthy lives—a prospect few of them had at the turn of the century. Globally, 73% of the estimated 39 million living with HIV were receiving HIV treatment in 2022, and 71% of them were virally suppressed.

The successes have been attributed, in part, to global solidarity around the HIV response, which has been shaped by:

- strategies with clear targets defined in global political commitments and country strategic plans;
- an architecture with global institutions driving multisectoral action, significant funding and market-shaping approaches;
- National AIDS Coordinating Authorities (NACAs) characterized by a unique integration of affected communities in their governance and operations;
- actions led by communities and civil society organizations;
- promotion of legal and policy frameworks aimed at safeguarding access to equitable HIV services and deterring discriminate and;
- a pioneering focus on indicator-based programme monitoring and ongoing course correction, which has become a global practice for public health programmes.

Despite the impressive progress, an estimated 1.3 million people globally acquired HIV in 2022 and over 9 million of the 39 million people living with HIV were not receiving HIV treatment. On closer examination, HIV responses are performing unevenly, with significant variations between places and populations. Vulnerable and key populations are especially affected by disparities in access to HIV services, tools and support.

NACAs have gained experience in leveraging the multisectoral infrastructure built around the HIV response for broader public health responses. This is reflected in their expanded mandates which increasingly also include sexually transmitted infections (STI), tuberculosis (TB), health education and demand creation, community engagement, and resource mobilization and allocation for public health. This amplified role became especially visible

during the COVID-19 pandemic. Inspired by these experiences, NACA directors-general established a community of practice in 2019, the HIV Multisector Leadership Forum, to strengthen peer-exchange and accountability for progress, cross-country support and collective voice in the global health agenda.

NACA directors-general have taken note of the evolving HIV response landscape and global context, including:

- disparities between countries and populations' access to health care and other crucial services (highlighted by COVID-19);
- a global push to transform large, vertical health programmes into integrated models; and
- an ongoing need for enabling legal and policy environments.

Other challenges such as chronic care costs, pandemic preparedness needs, a focus on universal health coverage, and climate change imperatives are expected to limit the financial resources available for HIV. HIV prevention is particularly vulnerable to further funding constraints, given the comparatively low investments in national prevention systems and the fragmentation into disparate projects and programmes.

The anticipated transitions and challenges demand a renewed and strengthened leadership that can consolidate the gains made, galvanize action to overcome disparities in the context, and expedite progress for the HIV response, broader public health and future pandemic preparedness. Therefore, it is proposed that NACAs, via the HIV Leadership Forum, will:

- Draw on their strengths and experience in managing the HIV and COVID-19 responses to promote the value of multisectoral expertise and infrastructure as a crucial platform for meeting current and future public health challenges.
- Emphasize the power of collective political commitment, sustained government action, and the joint actions of global and country stakeholders.
- Use the opportunities offered by ongoing transitions to define what country-led sustainability entails and to determine the most relevant ecosystems for designing HIV service models that can both leverage and integrate with wider national health, social and economic systems. Investments will be targeted toward strengthening the requisite leadership and management capacities to inform and shape the sustainability discourse as a country-led agenda.

- Invest in building national HIV prevention systems that have system-wide relevance, for example in to relation to workforces, procurement and supply chains, diagnostic platforms, demand creation, service delivery, and programme monitoring and accountability. Costings of HIV prevention will be developed as a basis to advocate for increased domestic financing and to secure additional resources for community-led and -based organizations.
- Act as collective voice and instrument to bring country knowledge to regional and global decision-making, and reduce transaction costs between global and regional level decision-making and country action.

This paper reflects on the history of the HIV response and the experiences of NACAs in the HIV (and, recently, COVID-19) responses in order to plot a path forward in the current operating environment. It makes the case for sustaining effective leadership of NACAs to secure gains, bridge disparities and expedite progress for the HIV response, broader health and in preparing for pandemics.



In the 1980s, the HIV epidemic was rapidly spreading, with AIDS-related mortalities rising sharply. Civil society organizations around the world were mobilizing. The predecessor of the Global Network of People Living with HIV/AIDS (GNP+) was established in 1986, and the following year saw the creation of the activist organization ACT UP in the United States of America and the AIDS Support Organisation (TASO) in Uganda. Initial global efforts were focused on prevention and then, after regulatory approval of the first antiretroviral (ARV) medicine in 1987, increasingly also on treatment.

1.1 THE GLOBAL HIV RESPONSE ARCHITECTURE

The World Health Organization (WHO) launched the Global Programme on AIDS in 1987 to galvanize and guide a global response to the epidemic. It designed the first Global AIDS Strategy. In 1996, the Programme was succeeded by the Joint United Nations Programme on HIV/AIDS (UNAIDS), which was created on the basis of a 1994 resolution of the Economic and Social Council of the United Nations. The purpose of the Joint Programme was to achieve a unified, multisectoral and coordinated response to an epidemic with dramatic health, social, economic, and human rights dimensions.

UNAIDS sought to align the activities and policies of several UN agencies, which joined the Programme as "Cosponsors". It assumed the role of leader, advocate and coordinator of the global HIV response and advocated for stronger top-level political leadership against the epidemic, increased resources for HIV programmes, and actions to reduce stigma and discrimination and uphold people's human rights. UNAIDS was also responsible for tracking and reporting on the evolution of the global epidemic and responses, including collating and sharing HIV-related data.

WHO, a founding Cosponsor of UNAIDS, continued to play a key role in the medical aspects of the disease. In 2001, shortly after the first United Nations General Assembly Special Session on AIDS, the Global Fund for AIDS, Tuberculosis and Malaria (Global Fund) was created to pool international resources and direct funding to countries for their programmes to combat those three diseases. In 2003, the United States Government launched

1.

A HISTORICAL CONTEXT OF THE HIV RESPONSE

the President's Emergency Plan for AIDS Relief (PEPFAR), which soon became the largest bilateral source of funding in the world for HIV responses. By 2023, PEPFAR was contributing almost US\$ 6.9 billion annually to national HIV responses.

The availability of ARVs for treating HIV sparked a global movement demanding affordable access to treatment for all people living with HIV. Price and patent negotiations led to agreements that allowed some countries to manufacture or purchase ARVs at reduced prices. The Medicines Patent Pool was set up (by UNITAID) to increase access to and facilitate the development of life-saving medicines for low- and middle-income countries.

The formation of UNAIDS was a landmark in the evolution of AIDS coordinating bodies. Eventually comprising 11 UN entities, UNAIDS set the precedent for collaborative global action. It would emphasize the multisectoral nature of the response; develop global AIDS strategies; pioneer the use of HIV surveillance and data for designing, implementing and monitoring HIV programmes; galvanize political commitment; mobilize resources internationally and domestically; and advocate for expanded prevention, testing and treatment programmes that are free of stigma and discrimination. Affected communities played central roles in the HIV response from the outset and achieved representation in decision-making forums at UNAIDS, regionally and in many countries.

1.2 COUNTRY-LEVEL HIV RESPONSE ARCHITECTURE AND ORGANIZING

By the late 1990s, the HIV epidemic was spreading rapidly in sub-Saharan Africa, decimating communities and straining health systems. Ministries of health had created AIDS committees in the 1980s, which focused on blood screening and sentinel surveillance, before initiating HIV testing and counselling programmes. However, these medically orientated committees were not equipped to lead prevention programmes or coordinate initiatives that spanned other sectors¹. Starting in the early 2000s, National AIDS Coordinating Authorities (NACAs) were established as semi-autonomous coordinating bodies with mandates to coordinate multisectoral HIV-related activities².

¹ WHO; the United Children's Fund; the United Nations Development Programme; the United Nations Population Fund; the United Nations Educational, Scientific and Cultural Organization; the World Bank; the United Nations High Commissioner for Refugees; the World Food Programme; the International Labour Organization; the United Nations Programme on Drugs and Crime; and the International Organization for Migration.

² The abbreviation "NACA" is used in this paper to refer to the various forms of AIDS coordinating authorities, including AIDS commissions, boards, councils, authorities and more.

1.2.1 National AIDS Coordinating Authorities

The aim of the NACAs was to consolidate national HIV responses by providing strategic leadership and coordinating multisectoral (or multi-ministerial) and multi-stakeholder activities. Reducing the rapid increases in new HIV infections and AIDS-related deaths were the priorities³.

Two broad models of NACAs emerged. In one, NACAs operated as stand-alone institutions with an autonomous mandate and based either inside or outside ministries of health. In the other model, NACAs were units within ministries of health⁴. Whereas national AIDS councils operated independently outside ministries of health, AIDS control units situated inside those ministries continued to provide health-related services. Reporting to the political executive occurred either directly or via ministries of health.

Countries applied different legislative and policy instruments to establish NACAs. A general principle was the stakeholder engagement in the governance and operational mandates of NACAs. This became increasingly pronounced over time, creating pathways for greater community engagement and action in the public health space. In the mid-2000s, the "Three-Ones" principle was introduced to boost effective coordination of resources and partnerships. It called for one national coordinating body, one national plan, and one monitoring and evaluation framework. The mandates of NACAs tended to emphasize: (1) policy formulation; (2) coordination of the national HIV response; (3) resource mobilization; and (4) monitoring and evaluation of the national response^{5,6}. Countries adopted various institutional arrangements, governance, financing, roles and responsibilities, depending on their national contexts.

TABLE 1 – Institutional setup of AIDS Coordinating Authorities

COUNTRY	AIDS COORDINATING AGENCY	INSTRUMENT ESTABLISHING NACA	REPORTING STRUCTURE	HIV LAW/POLICY NAME
Angola	Instituto Nacional de Luta Contra Sida (INLS) - National Institute for the Fight Against AIDS	Cabinet decree	Office of the President	The HIV and AIDS Law 8/04 of 2004
Botswana	National AIDS Coordinating Agency	Presidential Directive	Office of the President	National Policy on HIV/AIDS
Brazil	Department of Chronic Condition Diseases and Sexually Transmitted Infections	Ministry of Health	Ministry of Health	Law No. 12,984, on HIV discrimination
Cameroon	Comite National De Lutte Contre Le Sida (National AIDS Control Committee)	Presidential Decree	Office of the Prime Minister	Law No. 2005/006 of December 2005
China	National Center for AIDS/STD Control and Prevention (NCAIDS)	China CDC	Ministry of Health	Regulation on AIDS Prevention and Control
Colombia	National AIDS Council	Ministry of Health		Law 972 of 2005 – Promotion of Prevention, comprehensive Care and protection of the rights of people living with HIV and AIDS
Côte d'Ivoire	Conseil National de Lutte contre le SIDA" (CNLS), - National Council for the Fight Against AIDS	Decree No. 96-520 of 1996.	Office of the President	Law no. 2014-430: Loi relative à la prévention, à la protection des personnes et à la répression en matière de VIH/SIDA". (Law on the Prevention, Protection of Persons, and Repression in matters of HIV/AIDS)
Democratic Republic of the Congo	National Multisectoral Programme to Combat HIV/AIDS" (PNMLS) - (National Multisectoral Programme to Combat HIV/AIDS).	Presidential Order	Office of the President	Ordinance No. 11/023 of 18 March 2011 amending and supplementing Decree No. 04/029 of 17 March 2004 on the creation and organization of the National Multisectoral Programme to Combat AIDS, abbreviated "PNMLS"

COUNTRY	AIDS COORDINATING AGENCY	INSTRUMENT ESTABLISHING NACA	REPORTING STRUCTURE	HIV LAW/POLICY NAME
Eswatini	National Emergency Response Council on HIV and AIDS(NERCHA)	King's Decree	Office of the Prime Minister	HIV and AIDS Prevention and Control Act" of 2018.
Ethiopia	HIV/AIDS Prevention and Control Office (HAPCO)	Cabinet decree	Ministry of Health	Various guidelines and policies but not a specific act.
Ghana	Ghana AIDS Commission (GAC)	Presidential decree	The President's Office	Ghana AIDS Commission Act of 2016 (Act 938)
India	National AIDS Control Organisation(NACO)	Government Initiative	Ministry of Health & Family Welfare	HIV and AIDS (Prevention and Control) Act, 2017
Indonesia	No coordinating Agency present - KPAN dissolved by Presidential Order in 2017	Presidential Decree	The President's Office	Law No. 23/1992 regarding Health.
Islamic Republic of Iran	No separate agency		Ministry of Health & Medical Education	Various guidelines and policies but not a specific singular act
Kenya	National Syndemic Diseases Control Council	Executive Order under the State Corporations Act	The Ministry of Health	HIV and AIDS Prevention and Control Act, 2006
Lesotho	National AIDS Commission Lesotho	Government decree	The Prime Minister's Office	Various policies but not a specific act
Madagascar	National Committee for the Fight against AIDS	Government decree	Ministry of Health	Law 2005-040 on the Fight against HIV/AIDS and the Protection of Rights of People Living with HIV
Malawi	Malawi National AIDS Commission	Act of Parliament	The Office of the President	HIV and AIDS (Prevention and Management) Act" of 2018
Mauritius	National AIDS Secretariat	Government decree	Ministry of Health and Quality of Life	HIV and AIDS Act, 2006
Mexico	The National Center for the Prevention and Control of HIV/AIDS (CENSIDA)	Established by the Government	Ministry of Health	National Law for the Prevention and Control of HIV/AIDS" of 1999
Mozambique	Conselho Nacional de Combate ao SIDA (CNCS)	Presidential initiative	The President's Office	Various policies but not a specific act

COUNTRY	AIDS COORDINATING AGENCY	INSTRUMENT ESTABLISHING NACA	REPORTING STRUCTURE	HIV LAW/POLICY NAME
Namibia	Namibia National AIDS Committee (NAC)	National AIDS Policy	The Prime Minister's Office	National Policy on HIV/AIDS, 2007
Nigeria	National Agency for the Control of AIDS (NACA)	Act of the National Assembly	The President's Office	HIV and AIDS (Anti-Discrimination) Act, 2014
Pakistan	National AIDS Control Programme (NACP)	Government Initiative	Ministry of National Health Services, Regulation, & Coordination	Various policies but not a specific act
Philippines	Philippine National AIDS Council (PNAC)	Presidential decree	The President's Office	HIV and AIDS Policy Act" of 2018
Rwanda	Rwanda Biomedical Centre's HIV/AIDS, STIs, and other Blood Borne Infections	Government decree	Ministry of Health	Law N° 43/2013 of 16/06/2013 on Reproductive Health
South Africa	South African National AIDS Council(SANAC)	Cabinet Mandate	The Ministry of Health	Various policies and the broader "Constitution of South Africa" which prohibits discrimination.
South Sudan	South Sudan AIDS Commission (SSAC)	Presidential Decree	The President's Office	Various policies but not a specific act
Tanzania	Tanzania Commission for AIDS (TACAIDS)	Act of Parliament	The Prime Minister's Office	HIV and AIDS (Prevention and Control) Act, 2008
Uganda	Uganda AIDS Commission (UAC)	Act of Parliament	The President's Office	The Uganda AIDS Commission Act of 1992
Ukraine	Public Health Centre of Ukraine	Government Decree	Ministry of Health	Law on Prevention of AIDS and Social Protection of Population
Zambia	National HIV/AIDS/STI/TB Council (NAC)	Act of Parliament	The President's Office	National HIV/AIDS/STI/TB Policy
Zimbabwe	National AIDS Council (NACZ)	National AIDS Council of Zimbabwe Act	The President's Office	Public Health Act" and "National AIDS Council of Zimbabwe Act" of 1999

1.2.2 National AIDS Coordinating Authorities as stewards of the HIV response

Prior to the formal establishment of NACAs, countries such as Uganda were emphasizing health education to increase awareness about AIDS and the serious challenges of stigma and discrimination. Political leaders often provided vocal support to these activities, with NACAs helping to broaden those efforts. They worked with parliamentary AIDS committees to mobilize resources for HIV programmes, support community actions and enact legislation to address stigma and discrimination.

An important development was the World Bank's Multi-Country AIDS Program (MAP), which was set up in 2000 to provide countries in Africa with rapid and flexible funding. MAP funds were channeled through national ministries of health, with NACAs acting as implementing agents. Generally, the grants supported the expansion of HIV prevention (including for mother-to-child transmission of HIV); mobilization of political leaderships; capacity building for community-based (CBOs) and nongovernment organizations (NGOs); support for orphans and vulnerable children; monitoring and evaluation; and, eventually, HIV treatment.

Dozens of countries drafted national AIDS strategies, typically under the leadership of their NACA. These strategies set out priorities and principles for national HIV responses and were aimed at rallying stakeholders around common country goals, targets and approaches. The strategies continued to be managed by NACAs and serve as a basis for accessing funding from the Global Fund and PEPFAR.

A key feature of these multisectoral HIV responses was the integration of people living with HIV and other affected communities, civil society organizations, the scientific and academic communities, and policy-makers in the governance and management of NACAs and in programme implementation. MAP grants administered by NACAs, and then sub-granted to civil society organizations, were the beginnings of what would eventually become social contracting mechanisms in the health sector.

The work of NACAs was anchored in HIV surveillance and data collection. National AIDS monitoring and evaluation



³ Angola, Botswana, Cameroon, DRC, Ethiopia, Ghana, Kenya, Lesotho, Malawi, Mozambique, Namibia, Nigeria, Rwanda, Senegal, Somalia, South Africa, Eswatini, Tanzania, Uganda, Zambia and Zimbabwe

frameworks were pioneered and eventually became the basis for rigorous programme monitoring based on evolving sets of indicators—systems that became a global practice for public health programmes generally. Pioneered by Kenya's National AIDS Control Council, among others, subnational HIV estimates eventually became the global standard for granular data which the UNAIDS-managed Global AIDS Monitoring system currently uses.

NACAs also adopted the "greater involvement of people living with HIV" (GIPA) principle. National- and community-level campaigns, supported by NACAs and implemented by communities, CBOs and NGOs sought to reduce HIV-related stigma and create conducive environments for successful prevention, testing and treatment programmes. NACAs continue to support these activities, which now include Stigma Index surveys, and to conduct HIV-related advocacy. Every year, NACAs use World AIDS Day to retain public and political attention on the HIV epidemic.

Starting in the 2000s, greater attention was directed at population groups which experience very high risks of HIV infection. Termed key populations, they include gay men and other men who have sex with men, sex workers, people who inject drugs, prisoners, and transgender people. Alongside efforts to increase funding and other resources for HIV programmes for key populations, restrictive legal and policy environments become a greater focus of attention. Strong evidence also emerged of women and girls' disproportionate HIV vulnerability and risk in much of sub-Saharan Africa. This led to an array of programmes and initiatives aimed at reducing HIV infections in women and girls and at addressing the underlying factors for their heightened risk, including gender-based discrimination and violence.

National AIDS strategies increasingly reflected these priorities and efforts were stepped up to enhance HIV services for these populations.

The NACAs also experienced challenges, including difficulties implementing the "Three Ones" approach and challenges related to the management of HIV funds. Remedies were proposed, including the establishment of multisectoral "compacts"⁷ and the introduction of national fund managers to better coordinate



stakeholders at country level. Zimbabwe was among the countries to implement the recommendations; it also set up its pioneering AIDS Levy to increase domestic funding for its HIV programmes.

Overall, NACAs emerged as crucial entities responsible for monitoring the epidemic, developing strategic responses, ensuring resource allocation, strengthening community action, coalescing multi-stakeholder and multisectoral investments, and facilitating international cooperation.

1.2.3 HIV coordination infrastructure increasingly applied to broader public health

NACAs have evolved with respect to their mandates, functions and legal status in response to shifting needs and contexts. Originally set up for an emergency response, they have become multifaceted agencies. In Nigeria, for example, the mandate broadened to include direct programme implementation, advocacy, research, policy guidance and resource mobilization. Philippines's 2018 HIV and AIDS Policy Act expanded the mandate of its NACA to ensure accessible HIV services and uphold the dignity of people living with HIV. In Zimbabwe, AIDS Levy resources enable the NACA to strengthen its role in coordinating HIV-related mechanisms, while Côte d'Ivoire expanded the mandate its NACA to include comprehensive protection to people living with HIV.

Many Governments also extended their work to include HIV-related coinfections, including Rwanda, South Africa and Zambia. Following the COVID-19 pandemic, countries further adapted their NACAs in a bid to strengthen their public health systems. Botswana's NACA became the Botswana National Aids & Health Promotions Agency, while the mandate of Kenya's NACA was expanded to include STIs, TB and malaria programmes. Over time, the engagement of NACAs with health ministries strengthened and some reporting lines were moved from the political executive to those ministries, while maintaining their independent mandates. Despite the changes, NACAs have retained the core principle of "one AIDS strategy, one AIDS coordination agency and one monitoring and evaluation agency".

The mandates for multisectoral HIV action continue to expand. In some countries, NACAs lead bilateral and multilateral

negotiations, for example by chairing PEPFAR and government negotiations on country operational plans, or as Global Fund country coordinating mechanisms. NACAs have also led the development of national investment cases for engaging donors and national treasuries on health financing priorities. These National AIDS Spending Assessments provide high-quality, longitudinal input into the national health accounts. NACAs also advise their national governments on trade and intellectual property issues that affect the HIV response.

These examples show that NACAs have evolved in step with changing conditions and needs, and continue to serve as foundations for national HIV responses.

1.3 THE EVOLUTION OF THE HIV RESPONSE

Widening access to life-saving treatment and steady reductions in new HIV infections have shifted the epidemic in most countries from an emergency to a chronic care condition. To some degree, this was reflected in the transition from HIV meriting a stand-alone Millennium Development Goal in 2000 to becoming one of several health priorities highlighted in Sustainable Development Goal 3.3 in 2015.

The 1990s were characterized by great urgency to fully understand and control a rapidly spreading epidemic. Research focused on understanding the pathogenesis of HIV and developing effective diagnostics and treatments. Prevention efforts, largely directed by NACAs, were focused on awareness and education, and the promotion of safer sex practices. Health sector investments were targeted at surveillance and blood screening, voluntary counselling and testing, managing opportunistic infections, psychosocial care, and providing support to orphans through community networks. Also prominent was activism and advocacy to reduce HIV-related discrimination and stigma, and protect the rights of people living with and affected by HIV.

The development of effective ARVs amplified demands for affordable and equal access to treatment. In 2003, the WHO launched the "three by five" campaign, aimed at rallying global action to provide HIV treatment to three million people living with HIV in low- and middle-income countries by the end of 2005.

Funding available for HIV programmes increased dramatically, with NACAs overhauling national strategies and communities mobilizing and organizing for greater access to testing and treatment, and for their rights and entitlements. In many countries, vulnerable and marginalized populations organized and steadily entered decision-making spaces and access to resources. National health systems, supply chains and service delivery mechanisms were strengthened, especially for HIV activities. The "three by five" campaign was an important milestone: by 2010, the target had been comprehensively achieved and WHO launched its "Treatment 2.0" campaign to further expand the reach, quality and effectiveness of treatment programmes.

As treatment was scaled up, investments in HIV prevention lagged, however. Policy-makers, health-care planners and donors wrestled with complicated ethical, fiscal and political considerations⁸, but in most countries, the bulk of HIV investments, particularly those sourced domestically, went towards testing and treatment programmes. The tension between treatment and prevention priorities seemed to diminish when strong evidence emerged showing HIV treatment could reduce a person's viral load to such low levels that onward transmission of the virus became highly unlikely⁹. HIV treatment was incorporated as a key component of a combination prevention¹⁰.

By 2015, however, global targets for reductions of annual new HIV infections were clearly not being reached. Epidemiological analysis showed that growing proportions of new HIV infections globally were occurring among key populations, many of which were still poorly served by national HIV programmes. HIV high incidence also remained extremely high among adolescent girls and young women in much of sub-Saharan Africa. The 2016 UN Political Declaration on HIV and AIDS re-emphasized prevention, setting specific targets and calling for increased resources for prevention. In 2017, UNAIDS and UNFPA set up the Global HIV Prevention Coalition and in 2019 the directors-general of several NACAs set up a community of practice, which became known as the HIV Leadership Forum.

2.

HIV PREVENTION SITUATION ANALYSIS

2.1 CURRENT STATUS OF HIV PREVENTION

UNAIDS data show that 29.8 million of the estimated 39 million [33.1 million–45.7 million] people living with HIV globally were receiving life-saving treatment in 2022 and 71% of people living with HIV had suppressed viral loads. Approximately 1.3 million people (all ages) acquired HIV in 2022, 38% fewer than in 2010, and the number of new infections in children globally fell to 130 000, the lowest level since the 1980s. About 82% of pregnant and breastfeeding women living with HIV now receive ARV drugs to protect their health and prevent vertical transmission of HIV, up from 48% in 2010. Coverage is even higher in eastern and southern Africa, at 93%. Programmes for preventing vertical transmission of HIV (from mothers to children) are credited with averting 3.4 million infections in children since 2000¹¹.

However, key populations everywhere, and women and adolescent girls especially in sub-Saharan Africa, continue to be at very high risk of HIV infection. Primary prevention programmes for these populations are not achieving sufficient coverage and effectiveness. The availability and use of condoms and pre-exposure prophylaxis (PrEP) fall short of what is needed. Harm reduction services for people who inject drugs remain scarce in most of the countries where injecting drug use has been documented¹². In addition, programmes have not yet dislodged many of the factors that generate high HIV vulnerability and risk, including social, economic and gender inequalities, legal and policy hindrances, and widespread stigma and discrimination.

2.2 OVERCOMING THE BARRIERS TO HIV PREVENTION

Several challenges for HIV prevention must be addressed. NACAs are tasked with stewardship, data oversight and convening roles, and with promoting enabling social, structural and legal environments to accelerate and sustain gains made in the HIV response. Ministries of health are responsible for implementing prevention, testing and treatment programmes. Several gaps in national prevention management systems have been identified, for example in relation to planning, supply forecasts and chains, technical and human capacities, and performance monitoring.

Most countries retain laws that criminalize sex work, same-sex relations or the possession of narcotics, which undermines equitable

access to prevention services for people belonging to key populations. Social and structural barriers such as poverty, low school enrolment rates, gender discrimination and gender-based violence increase the risk of acquiring HIV and reduce the ability to access and use HIV services and tools. Adolescent girls and young women face structural barriers in access to information and services. Directing greater resources and mobilizing stronger efforts towards tackling those factors requires sustained advocacy and coordinated actions. Those are important priorities for NACAs, which need to strengthen enabling environments and create greater opportunities for access to safe and quality services.

Although the HIV response has generated many good practices, coordination between international institutions and, particularly, harmonization within national agendas and structures has suffered. As far back as the early 2000s, one of the challenges for implementing the "Three Ones" model was the existence of numerous multisectoral coordination structures with overlapping focus and membership. Different funding streams also tend to lead to disparate coordinating and reporting processes and systems that do not always link with existing national ones. The decision-making and design of some prevention programmes are donor-driven, which tends to lead to fragmented and duplicated interventions. In some cases, multiple data collection systems exist in parallel to government systems. Pertinent data collected by donor funded projects are also not always shared with country governments or collated in national information management systems, leading to data gaps. Technical assistance for HIV prevention has tended to involve short-term consultancies with limited understanding of country context and focus on technical outputs, with less attention devoted to management and systems strengthening. (This has begun to shift due to interventions such as the South-to-South Learning Network, which leverages country experience.)

Overall, financing for HIV prevention has continued to lag in a context of diminishing donor resources for HIV and the financial pressure of sustaining treatment programmes. In addition, cost data on HIV prevention is based on spending by donor-funded programmes, not on actual costs of nationally managed services and systems. Thus, at national level, appeals for investment in prevention interventions are not always costed and presented in ways that meet national budgeting requirements. There are also limited investments in the advocacy with national treasuries and parliaments that is required to promote the prioritization of HIV prevention budgets.



3.1 REVITALIZING THE HIV PREVENTION RESPONSE

3.

HIV Prevention towards 2030

3.1.1 *The Global HIV Prevention Coalition*

Established in 2017, the Global HIV Prevention Coalition is aimed at strengthening and sustaining political commitment and investment for primary prevention in countries with high numbers of new HIV infections by setting a common agenda among key policy-makers, funders and programme implementers. The Coalition currently has 33 country members and it also includes donors, civil society organizations, UN agencies and community networks.

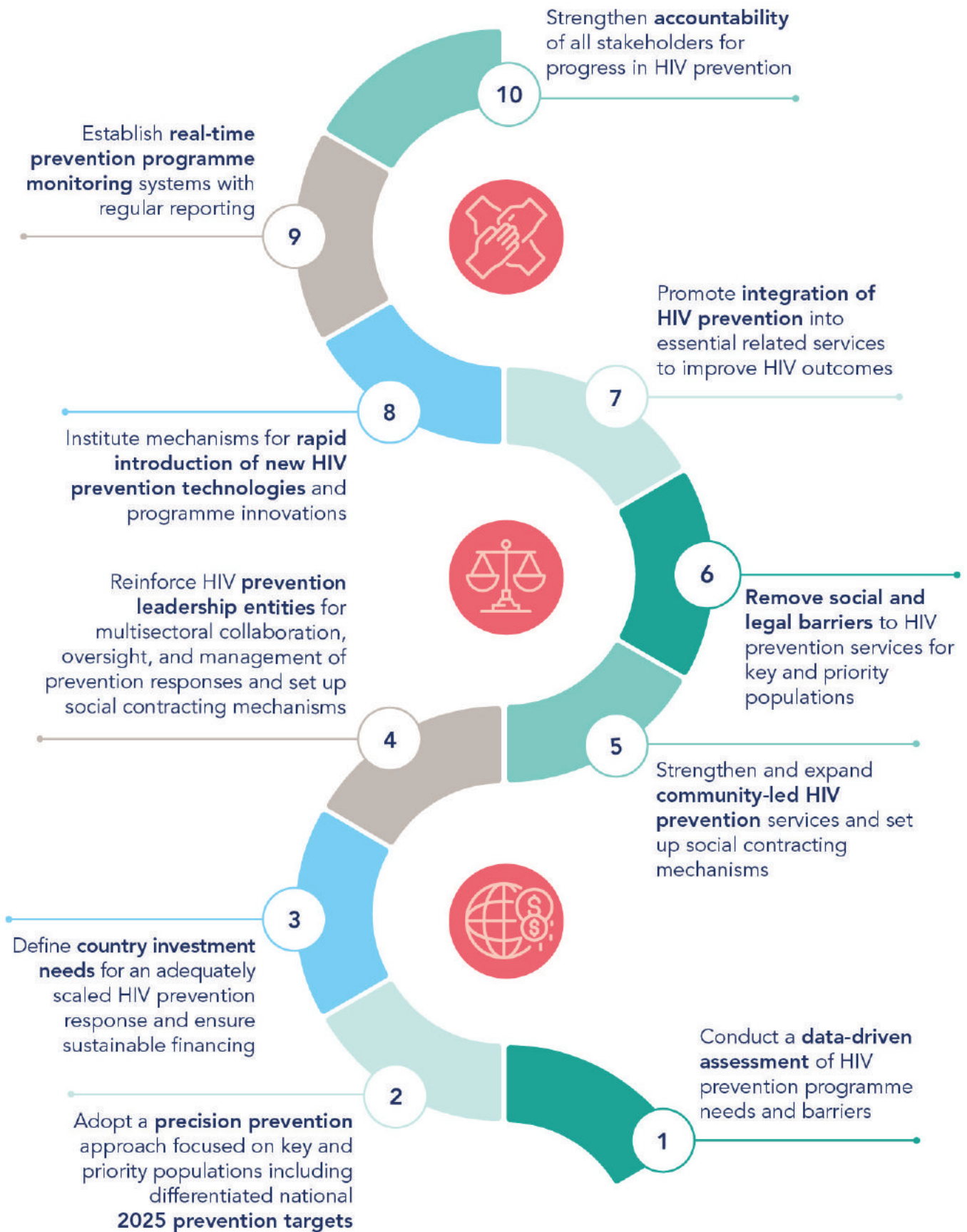
3.1.2 *The Global HIV Prevention Roadmap 2025*

The Coalition has developed two sets of road maps to guide actions that can close gaps and remedy shortcomings in prevention programmes, for 2020 and 2025^{13,14}. The latest iteration, the 2025 Road Map, identifies five key pillars for programming and interventions related to key populations, adolescent girls and young women, and adolescent boys and men. It also lays out a ten-point action plan (see Figure 1) that aims to reduce new HIV infections to fewer than 370 000 annually by 2025.

The five prevention pillars are:

1. **Key Populations:** combination prevention and harm reduction packages for and with sex workers, gay men and other men who have sex with men, people who inject drugs, transgender people and prisoners.
2. **Adolescent Girls and Young women:** combination prevention packages in settings with high HIV incidence.
3. **Adolescent boys and men:** combination prevention packages in settings with HIV incidence, including voluntary medical male circumcision and promoting access to testing and treatment.
4. **Condom Programming:** promotion and distribution of male and female condoms, as well as lubricants.
5. **Antiretroviral-based prevention:** PrEP and treatment as prevention, including for the elimination of vertical transmission.

Figure 1. – The ten-point action plan in the HIV Prevention 2025 Road Map



3.1.3 The HIV Leadership Forum, a community of practice of directors-general of National AIDS Coordinating Authorities

The community of practice of directors-general of NACAs was established in 2019 with the support of the Global HIV Prevention Coalition. It was intended to serve as a platform for accelerating actions outlined in the HIV Prevention 2020 Road Map, by leveraging and strengthening national prevention leadership and accountability, and driving implementation through the NACAs. It recognizes the strengths of NACAs as drivers of a multisectoral response for enhancing public health.

In 2020, the Forum provided inputs into the Global Fund strategy for 2023–2028 (via the Africa Constituency Bureau) and the Global AIDS Strategy 2021–2026. At country level, NACAs mobilized political support through ministerial meetings and commitments between 2019 and 2023, as outlined in the GPC NAC Directors' Community of Practice brief of 2021¹⁵. Several other interventions are also underway. Below are some examples of implementing the Prevention Roadmap.

- Zimbabwe is addressing Action Point 5 in the HIV Prevention 2026 Road Map by establishing social contracting mechanisms. It also has developed policy guidelines for the "Government of Zimbabwe Public Financial Support to Civil Society-Led HIV and AIDS Service Delivery and Systems" initiative, which the National AIDS Council is implementing.
- The South African National AIDS Council is addressing Action Point 4 by reinforcing prevention leadership through a multisectoral coordinating structure that comprises government departments, as well as civil society, development and private sector partners. Donor coordination, Global Fund country coordinating mechanism and programmatic review teams that include the Ministry of Health report through a single structure.
- Nigeria National Agency for the Control of AIDS is addressing Action Point 3 by transitioning donor-funded HIV services into national systems. A four-phase process is aimed at ensuring that diagnostic and supply chain systems, and health workforce and management capacities are government-managed by 2024.
- Uganda is focusing particularly on Action Point 3. As part of the presidential fast-track initiative for ending AIDS by 2030, all Government ministries, departments and agencies

are required to allocate 0.01% of their budgets. With over 90% compliance in 2022, US\$ 10 million was allocated by the Finance Planning and Economic Development Ministry to the Uganda AIDS Commission for directing the implementation of HIV programmes. The next step is to identify avenues for using the ring-fenced resources effectively within the requirements of the Finance Act.

- In 2021/2022, Kenya focused on Action Points 1 and 2. HIV epidemic appraisals were used to identify priority geographies, populations, and preferred platforms and delivery models based on analysis of HIV incidence, coverage of prevention interventions and other programming data. The findings are informing national HIV prevention programming.

In 2023, the HIV Leadership Forum developed its terms of reference, appointed a steering group and produced this position paper. The Forum recognizes that there are both challenges to be met and opportunities to be grasped.

3.2 NEW CONTEXTS, CHALLENGES AND OPPORTUNITIES

3.2.1 Universal Health Coverage

Following the 2019 UN Political Declaration of the High-level Meeting on Universal Health Coverage, countries have invested anew in promoting access to quality health care and financial protection for all. They are defining their Universal Health Coverage packages and adapting legislation and policies to strengthen health systems for data, diagnosis, supply chains and services, primary health care, health sector capacities and infrastructure.

The HIV response has already attained Universal Health Coverage in some countries and communities, and is on the path to achieve it in many others. NACAs have an opportunity to shift the narrative from "How does HIV fit within the Universal Health Coverage agenda?" to "What can the Universal Health Coverage agenda learn from HIV in order to succeed?". The "leave no one behind" vision of Universal Health Coverage, for example, implies a multisectoral approach, which NACAs are highly experienced in applying. Universal Health Coverage is an opportunity for NACAs to apply valuable lessons from the HIV response—including the

crucial roles of community-led, people-centred and rights-based services—to the broader public health sphere.

OPPORTUNITIES:

With integration increasingly seen to be essential for sustainability, NACAs can use costings of HIV prevention and treatment programmes to shape discussions about the inclusion of HIV in national essential health service packages.

3.2.2 COVID19 Pandemic Preparedness,

Prevention and Response

The COVID-19 pandemic focused renewed attention on access to health commodities and technical assistance for public health. It also showed the adaptability and resilience of health systems in many low- and middle-income countries. Especially in sub-Saharan Africa, countries adapted their responses as the pandemic evolved, with community organizations playing key roles in supporting and sustaining essential health services, including for HIV.

In several countries, NACAs helped guide the establishment of multisectoral COVID-19 responses, as well as perform specific roles. For example, they were tasked with resource mobilization in Kenya; the coordination of cadres of community health workers in South Africa; resource re-allocation to community responses in Zimbabwe; and leveraging HIV programmes for mass testing in Ghana. They also assisted in planning course corrections and provided coordination platforms in several countries.

OPPORTUNITIES:

Key factors that shielded the health systems in many African countries from collapse during the pandemic included: top-level political leadership; functional multistakeholder and multisectoral structures; the effective use of health system capacities; the integration of community organizations and networks; and the use of digital innovations¹⁶. The quest to achieve and sustain long-term quality of life and low-incidence outcomes for HIV can learn from the COVID-19 experiences. NACAs have an opportunity to review and repurpose their efforts towards reviving top-level political urgency around HIV prevention, developing country-led frameworks for sustainability, and serving as platforms for mobilizing investments for pandemic preparedness and for the mitigation of noncommunicable diseases.

“COVID-19 reminded us that the world has never won a war on a pandemic without a multi-sectoral collaboration”



3.2.3 Sustainability of the HIV response

Sustainability for prevention is generally understood as the ability of our countries to provide and maintain HIV prevention into the future. That implies important decisions and choice, which NACAs can help influence, for example: What targets do countries need to achieve and by when? What targets and timeframes are realistic, and levels of new infections can be tolerated over time? The answers to those questions will inform the mix and scale of interventions, and the investments and other resources that are required to implement them.

People using HIV services also require access other health-care, social and education services—access that is shaped by the conditions in which they live, and the inequities, discrimination and other rights violations they experience. Besides potentially increasing both service access and sustainability, the integration of HIV services with other health and social services can help address shifting health needs. For instance, modelling studies in Kenya indicate that people living with HIV are more likely to experience noncommunicable diseases (NCDs) in the future. The integration of HIV and NCD services then becomes imperative not only to prevent and treat NCDs, but also to safeguard the benefits of ART investments.

In addition to health sector integration, NACAs recognize that there are various opportunities for integration in other sectors. For instance, providing comprehensive sexuality education for adolescents and young people will require integration in education or social service sectors. Delivery of HIV services in countries that criminalize key populations requires engagement with social, religious and political actors, as well as with law enforcement and judicial sectors. The current discourse around sustainability leans towards transitioning elements of HIV services and systems into overarching, country-funded health programmes. All this offers opportunities.

Recognizing that HIV prevention interventions are largely disjointed and not at the required scale, NACAs can strengthen their responsibility for planning, implementation, monitoring and course correction. The HIV Leadership Forum will mobilize investments for strengthening the requisite management and coordination capacities.

Questions relating to "who will pay for what, and how" will define sustainability approaches. NACAs recognize that current costs of HIV programmes, especially prevention programmes, are based on emergency response, vertical programme designs rather than on national, horizontal programme designs, resulting in high programme and management costs. NACAs will engage in more detailed costing exercises, especially for HIV prevention, and seek to institutionalize National AIDS Spending Assessments that link and feed into National Health Accounts.

The availability of reliable and secure HIV and health products and technologies will remain a priority. The realization of the African Union's push to expand local manufacturing of health commodities will require strong political will, appropriate legal frameworks and regulatory and oversight capacities, large private sector investments, and transnational pooling of investments and markets. The multisectoral platforms within NACAs offer opportunities to bring together the various stakeholders that can achieve those changes.

As countries develop economically, they are expected to progressively and sustainably transition away from external financing and toward domestically funded health programmes. It is important to note that the backbone of HIV prevention and treatment programmes consists of government-financed health infrastructure, supply chains, diagnostic systems and workforces. However, there is an additional need for increased domestic resources within health budgets, including resources that are available for activities undertaken by civil society organizations (for example, via social contracting mechanisms). NACAs recognize that securing domestic financing through any mechanism requires engaging with national budgeting and financing cycles, processes and requirements, which are managed by national treasuries and often involve parliamentary or cabinet approvals.

OPPORTUNITIES:

The mandates of various NACAs have been expanded to include additional functions: those experiences with different political and technical processes can be shared fruitfully. NACAs also have the opportunity to inform (and perhaps even steward) integration approaches, using HIV prevention as a pathfinder. With regard to domestic financing, NACAs have an opportunity to engage and inform national medium-term expenditure frameworks to increase and direct resources towards HIV programme priorities.

3.2.4 Strategic Partnerships at Regional and Global Levels

Complementarity of the roles and functions of national governments, donors and communities is vital for improving people's quality of life and wellbeing. While HIV prevention is a shared responsibility, a great deal of the prioritization, funding, programming and service delivery has been donor-driven. Uncoordinated and disjointed activities reduce the efficiency of information flows, diminish the quality of results and outcomes, and increase transaction costs. NACAs, as the government entities responsible for accelerating progress towards the HIV Prevention 2025 Road Map targets and driving implementation of the 10-point action plan, can help address those hindrances.

NACAs can help harmonize decision-making and action between different actors and between the global, regional and country levels. They can amplify country voices and share valuable experiences in global and regional spaces. They have an opportunity to establish evaluation mechanisms that hold governments as well as donors and development partners to account for their performances at country level. That can strengthen mutual accountability by including assessments of the performance of global health partners for 360-degree assessments that includes countries, communities/civil society and development partners.



This position paper has reviewed the global HIV response, the evolving and expanding roles of NACAs, and the status of HIV prevention, including challenges and barriers, as well as identified key opportunities for NACAs.

The directors-general will promote their countries' HIV and health programming sustainability, recognizing that HIV incidence reductions are a gateway to overcoming the epidemic in the long term. Although countries are at different levels of implementation and management capacity, NACAs will continue to navigate their national challenges and contexts. Their decades of experience and their expertise and institutional strengths (including their legal mandates and subnational structures) are key assets for acting decisively across the five prevention pillars outlined in the HIV Prevention 2025 Road Map. They are also vital for creating the enabling environments and addressing underlying inequalities. More specifically, NACAs will undertake the following strategic pivots.

4.1 STRATEGIC PIVOT 1: STRENGTHEN MULTISECTORAL LEADERSHIP AND STEWARDSHIP

Multisectoral platform offer opportunities to harness the convening power of NACAs and to coordinate joint planning and action, strengthen accountability across strategic sectors, and optimize investments. The NACAs will undertake the following actions.

- NACAs will develop policy guidance for country-led, multisectoral responses. They will document the general principles, models and functioning of prioritized sectors such as health, education, law and justice, youth, gender and social services. They will define mechanisms and tools, structures and capacities for decision-making, as well as political and policy levers required for functional collaboration in the context of competing interests. They will identify the optimal roles of community and other civil society organizations, donors, government entities, private sector partners, scientists, service providers, political leaders and policy-makers in different sectors.
- Where NACAs have expanded mandates, the strengthened

4.

A MULTI-SECTOR RESPONSE: SECURING A SUSTAINABLE FUTURE

“The HIV multisectoral approach was a pathfinder for resetting the operating environments of health politics, systems and money resulting in unprecedented gains. We seem to have forgotten this past, yet it is the pathway to the last mile for HIV, to future pandemics and to sustainability”

multisectoral leadership will be applied also to benefit other areas of health and development such as TB, STIs and social policy.

- They will develop a 360-degree accountability framework that includes joint working mechanisms and performance indicators that are applied to all country stakeholders, including government, donors and development partners, communities and the private sector (current frameworks tend to monitor only government performances).

4.2 STRATEGIC PIVOT 2: BUILD STRONG NATIONAL HIV PREVENTION SYSTEMS

The HIV Leadership Forum notes that the current focus on HIV prevention and the scale and sustainability of prevention programmes and interventions rely on strong national management systems that cut across sectors and that are country-owned and country-led. The NACAs will undertake the following actions.

- NACAs will define the prevention management systems that are needed to expand and sustain prevention programmes at scale. In doing so, they will focus on: planning systems; performance management mechanisms; monitoring and reporting indicators, tools and structures; forecasting and quantification processes linked to the supply chain; and oversight and decision-making processes. Clear responsibilities for the various stakeholders and actors will be applied through an organized platform.
- They will focus on investing in human and technical capacities to strengthen the leadership, management and implementation of national HIV prevention programmes and systems.
- They will prioritize routine, data-based and joint stakeholder prevention system reviews at country level to review prevention systems and receive routine reports from technical teams reviewing programmes and interventions. The Forum will develop standard operating procedures for national prevention system reviews and for enhancing the visibility of key strategic information and data for action.

4.3 STRATEGIC PIVOT 3: INFORM AND SHAPE COUNTRY-LED SUSTAINABILITY

The HIV Leadership Forum will focus on defining and shaping country leadership in the ongoing sustainability discourse. With specific regard to HIV prevention, NACAs will ensure that HIV prevention is prioritized. The NACAs will undertake the following actions.

- They will provide leadership for redirecting HIV prevention resources by examining current spending and actual costs for prevention services; delivery system costs; community service costs; support costs such as demand creation; prevention commodity costs; and supply chain and management costs. The Leadership Forum will develop case studies to support advocacy with ministries of health and national treasuries for increased domestic resources and to serve as guidance for strengthened funding for community systems (for example, through social contracting).
- The NACAs will collectively define the key principles, anchor points, components and actors for a country-led sustainability framework that reflects countries' operating environments and priorities. They will provide a guided pathway for consolidating the HIV response within broader public health, while safeguarding the gains made (for instance, by ensuring that Universal Health Coverage package services include HIV prevention and treatment interventions). The multisectoral approach will be used to bridge disparities by dealing with the structural and legal factors that generate inequalities, vulnerabilities, stigma and discrimination.
- They will develop consensus and make proposals for the adoption of technical assistance models which are informed by countries' long-term needs and provided by parties who understand country realities. Technical assistance has to strengthen country leadership and management capabilities beyond programming and service delivery.

4.4 STRATEGIC PIVOT 4: ADVANCE A COUNTRY-LED HIV GLOBAL AND REGIONAL AGENDA

The HIV Leadership Forum will strengthen national voice in decision-making for the HIV response within regional and global

health institutions. The NACAs will undertake the following actions

- They will establish strategic partnerships with regional and global institutions and networks, and cultivate working relations that strengthen voice, local knowledge of programme design and sustainability options in global public health.
- They will develop and disseminate strategic documents (such as position papers) and make direct contributions to the Global HIV Prevention Coalition, UNAIDS, the Global Fund, UNITAID, PEPFAR, Africa Centres for Disease Control, the UNAIDS Programme Coordinating Board, the African Union, and regional economic communities.

The NACAs call on donors, technical agencies and partners to link with and harmonize with NACAs and in-country coordination mechanisms in the interest of optimizing results for HIV prevention and for public health overall.

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Sustaining Effective Leadership to Secure Gains, Bridge Disparities and Expedite Progress

A position paper on the leadership role of national AIDS coordinating authorities in the future of HIV prevention, sustainable health and preventing future pandemics

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