The Millennium Development Goals +15: What now for HIV?

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With the deadline for achieving the Millennium Development Goals approaching rapidly, policy-makers, academics and civil society actors are debating how successful the goals have been and what should replace them [1,2]. Success in meeting the goals has been at best patchy. Whilst targets on poverty, slums and water have been met [3] this has largely been attributed to the success of emerging economies, most notably China and India [2]. Other goals remain way off target and where progress has been made persistent levels of inequality are evident both within and across countries [3]. One school of thought is that the Millennium Development Goals reflect a flawed project that focused too narrowly on specific indicators of poverty and inequality rather than underlying sociological, political and economic factors. The argument follows that they should be replaced by an enhanced commitment nationally, internationally and globally to the broader goals of social justice, equity and good governance.

At a UN summit held in September 2013, world leaders met to discuss the MDG +15 agenda, as it has become known. It was noted that whilst great achievements had been recorded, the overall response had been too uneven, with significant gaps. Committing to scale up the response to extreme poverty, hunger and disease, a report published to coincide with the summit identified five 'big transformative shifts', cross-cutting themes, which participants argued should form a universal agenda for what comes next (see Panel 1).

The first of these shifts, *leave no one behind*, is described thus:

> We should ensure that no person – regardless of ethnicity, gender, geography, disability, race or other status – is denied universal human rights and basic economic opportunities. We should design goals that focus on reaching excluded groups [4].

For those of us concerned with the health and well-being of people living with HIV this clearly resonates. A human rights-based approach to HIV has been the cornerstone of policy and programming since the earliest days of the epidemic. Of course it is too early to say for sure how these five shifts will translate into action. Much of the detail is still up for debate. But nurses do need to be thinking about where HIV will fit in to the bigger picture of development post 2015. What does seem to be emerging is that there are unlikely to be disease-specific goals; rather, the approach may be for increased integration of cross-cutting issues.

Given this uncertainly, this paper will focus upon MDG 6, *Combat HIV/AIDS, Malaria and Other Diseases* (see Panel 2), and explore what 'leave no one behind' might mean in relation to the emerging agenda for an 'AIDS-free generation,' with particular focus upon middle- and low-income economies. What does an 'AIDS-free generation' mean in contexts where there is pervasive inequality, human rights abuses and enduring poverty? How can we respond to the challenge of reaching key populations? Has the vitally important renewed focus on biomedical approaches, such as treatment as prevention and male circumcision, led to a shift in focus away from other approaches to prevention? And, importantly for us as a professional group, how should nurses respond to these challenges?

But first, I want to take the opportunity to offer a personal reflection on the changes wrought in the provision of treatment to people living with HIV since the setting of the MDGs. In the rush to criticise it can be easy to overlook the remarkable changes that have taken place over the past 15 years. In the summer of 2000 I was in West Bengal, India, researching how global guidelines for HIV prevention and control, and care and support were being translated into action by non-governmental organisations. As a nurse who had worked in HIV in

Panel 1: Five big transformative shifts [4]

- Leave no one behind
- Put sustainable development at the core
- Transform economies for jobs and inclusive growth
- Build peace and effective, open and accountable institutions for all
- Forge a new global partnership

Panel 2: Millennium develpment Goal 6: combat HIV/AIDS, malaria and other diseases [5]

- Halt and begin to reverse, by 2015, the spread of HIV/AIDS
- Achieve universal access to treatment for HIV/AIDS for all those who need it
- Halt and begin to reverse, by 2015, the incidence of malaria and other major diseases

the UK I was repeatedly struck by the contrast between what was available to people 'back home' – with respect to care and support – and the limited options available to the people I met during the course of my research. A World Bank document discussing the rationale for the approach to be taken in the next phase of Indian HIV programming gives a clear indication of the thinking at that time:

> Providing Western-based treatment and care of AIDS cases for example triple therapy was rejected … these treatments are hugely expensive, remain palliative and are unlikely to have an impact upon HIV transmission [6].

Instead, the focus of care and support was to be the development of Low Cost Models For Community and Home-Based Care and Support with some ring-fenced money for the treatment of opportunistic infections via the public health care system. The reality of this was made clear to me by an outreach worker for sex workers talking about the problem of trying to support HIV-positive women:

> All of a sudden they disappear. One girl who was very close to us, she was gone for a few months … and then we heard that she had died. When the girls know that they have HIV they give up [7].

At that time it was impossible to imagine the changes that the following decade would bring.

Against this background, the most recent figures published by UNAIDS show that there has been a 30% drop in AIDS-related deaths since the peak in 2005. By the end of 2012 antiretroviral therapy (ART) had been made available to 9.7 million people living in low- and middle-income countries. This represents an increase of 20% in just one year [8]. In India this means that a reported 570,620 people now have access to ART. To reflect rapid progress the target set for access to ART was increased in 2011 to 15 million people by 2015, and recently the WHO revised its HIV treatment guidelines to reflect treatment as prevention, increasing the estimated number of people in need of HIV treatment by a further 10 million. UNAIDS also announced a 33% reduction in new infections amongst adults and children since 2001. As such, using the criteria set by MDG 6, globally the AIDS epidemic has been halted and reversed.

Speaking at the launch of the latest global report into the HIV epidemic, Michel Sidibe, Executive Director of UNAIDS, clearly echoing the MDG +15 agenda, said:

> Not only can we meet the 2013 target of 15 million people on HIV treatment – we must also go beyond and have the vision and the commitment to ensure that no one is left behind [9].

So there is undoubtedly much to celebrate. But it is too soon to be complacent. An estimated 1.6 million people died from AIDS-related illnesses in 2012, and 2.3 million people newly acquired HIV (see Panel 3). The UNAIDS report also highlights that in a number of key areas, ensuring respect of human rights, enabling people most at risk of HIV infection (particularly people who use drugs) access to HIV services, and the prevention of violence against women and men, progress has been slow. Punitive laws, discrimination and gender inequality represent persistent obstacles to the scale-up of national responses. Worryingly, in some countries where there has been a significant decrease in rates of infection, sexual-risk behaviours amongst young people seem to be on the increase.

Panel 3: 2012 estimates [10]

- 35.3 million (32.2–38.8 million) people globally living with HIV
- 2.3 million (1.9–2.7 million) people became newly infected with HIV
- 1.6 million (1.4–1.9 million) people died from AIDs-related illnesses

Behavioural interventions and structural interventions, as well as biomedical ones

The UNAIDS global report [8] highlights that prevention efforts aimed at men who have sex with men (MSM), sex workers and people who inject drugs (IDU) are insufficient and transmission rates remain stubbornly high. Men who have sex with men report a lack of availability of condoms and lubricants. Criminalisation and the very real threat of violence or even death continue to be major barriers preventing men who have sex with men and transgender people from accessing HIV services. Injecting drug users are similarly discriminated against, with many countries enacting punitive laws. Despite over 20 years of evidence for what works, people injecting drugs continue to be denied access to needle exchange services and opiate substitution therapy [8]. Pregnant women and children are also facing barriers to accessing HIV treatment services. A similar picture emerges for sex workers.

The common thread here is the importance of maintaining and increasing support for behavioural and structural interventions. There is a fear in some quarters that, with the possibilities of HIV prevention from ART and male circumcision, momentum may be lost on these vital programmes [11]. UNAIDS notes that:

> There are worrying signs that social and behavioural programming might now have a lower priority … however as new biomedical tools are rolled out, effective social-behavioural and structural programmes will not only remain

> essential in their own right but will also be needed to maximise the efficacy of biomedical approaches, including averting the possible emergence of risk compensation … behavioural and structural programmes also help to overcome barriers to service uptake, such as social exclusion, criminalization, stigma and inequality [8].

An associated theme is that of how to ensure community action, the bedrock of HIV prevention in low- and middle-income countries, is maintained and scaled up. With a funding base shifting from international donors (particularly in middle-income countries) to national level actors, non-governmental organisations and community-based organisations will need to develop new alliances with the public and private sectors in order to secure funding [12]. This may prove difficult if the national context is one of discriminatory laws and exclusionary social practices.

Funding

The picture of funding for HIV globally has been a worrying one in recent years. The global economic downturn has affected the willingness or ability of both bilateral and multilateral donors to meet their funding commitments to aid and development programmes. The cancellation of Round 11 of the Global Fund for AIDS, Tuberculosis & Malaria in the autumn of 2011 led to a significant reduction in dedicated funding for HIV, TB and malaria. This was described by the UN Reference Group on HIV and Human Rights as presenting the international community with 'both a health and a human rights crisis' [13]. Fortunately, since September 2013 there has been a renewed commitment from some quarters to increased funding to meet MDG 6's target for treatment of HIV [14]. The UK Department for International Development has pledged to give £1 billion to the Global Fund over the next 3 years provided that other donors also meet funding commitments. To date, both the USA and France have responded positively with increased commitments. DFID estimates that the extra funding will provide ART for 750,000 people [15].

To put HIV and AIDS into the wider context of health service provision, global institutions are also beginning to change their thinking on funding. There is a growing recognition that health is an essential precursor to economic development as well as a human right. This signals a return to the values and ethos of the Alma Alta Declaration and 'health for all' [16]. The imposition of user fees is now being widely rejected as a strategy for health funding with a new commitment to raising funding from public financing mechanisms (including taxation). Activists have long argued that numerical targets for single disease have led to fragmentation of both health priorities and systems [17] and unduly diverted funding away from health service strengthening. The WHO is promoting Health Service Strengthening by arguing for Universal Health Coverage and primary health care [18]. Research for universal health coverage is the theme of the WHO's 2013 World Health Report [19]. The World Bank is also on the record as rejecting user fees and promoting Universal Health Coverage:

> The aims of universal coverage are to ensure that all people can access quality health services, to safeguard all people from public health risks, and to protect all people from impoverishment due to ill health [20].

Only time will tell how successful this new approach is in ensuring that the most vulnerable, impoverished and excluded people are able to access the health care that they need. Certainly, looking back again at my time in West Bengal in 2000, the one thing that project workers spoke of more than anything else was their desire to respond to the 'felt needs' of their project users. To care for their health in its totality and to provide access to wider health services.

Implications for nurses and health workers

What then does all of this mean for nurses and health workers currently working in HIV/AIDS within resource-poor settings? One of the big stories in recent years has been the success of task shifting, where nurses or other health workers have taken responsibility for ART initiation and re-prescription. A study from 2012 found this could be done safely and improve health outcomes [21]. How nurses view this enhanced role is less well documented. What is clear is that nurses working in the field and in highly challenging situations need to be more engaged in the policy process and should be supported to actively shape health policy [22]. A paper exploring the experiences of nurses working in HIV prevention and care in six countries (Canada, Jamaica, Barbados, Kenya, Uganda and South Africa) found that respondents all reported a lack of involvement in policy development and the imposition of 'top-down' policies [23].

The need for nurses with experience of working in HIV to share their skills and expertise, and to train and support the development of colleagues, will become increasingly important as HIV treatment comes on stream and more and more people are living with HIV over the longer term. Indeed an emerging new challenge in HIV care is how to support an aging population who may have been taking ART for many years and have significant co-morbidities. As access increases, and as a 'normalisation' of the epidemic takes place, country-level health services will need to adjust and change to meet the challenge. Health workers who may have no experience of caring for people with HIV will need to skill up and incorporate HIV care within the wider remit of their professional practice.

This inevitably raises the spectre of stigma and discrimination that originates from within the health sector. The most recent UNAIDS report on the global epidemic, discussed earlier in this paper, identifies an urgent need for men who have sex with men to have access to 'culturally sensitive HIV counselling and testing and antiretroviral therapy' [8]. Describing this as a global health priority the report highlights the fact that the fear of disapproval and discrimination by health workers is a significant stumbling block in achieving this aim [8].

Concluding comments

The MDG +15 agenda is still under discussion. The exhortation to 'leave nobody behind' offers people living with HIV or AIDS, civil society actors, nurses and other health care workers an entry point into the global debate about where HIV should be situated in the new framework and what work still needs to be done. Globally, nurses have much experience to bring to this debate, not just in relation to HIV but to broader issues. Whilst acknowledging challenges faced by nurses in getting their voices heard in the policy arena, wherever possible nurses should endeavour to share their thoughts and experiences, their hopes and fears, and their aspirations for what HIV nursing will look like in the post-2015 world.

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