Aim of the side-event:
- To draw the attention of key policy makers, including civil society, to the importance of ensuring that both national development plans and national health plans give due and balanced attention to the NCD and HIV agendas.
- To review lessons learned and identify successful approaches and actions for health systems strengthening that can maximize synergies and efficiencies in HIV and NCD prevention, treatment and care at global and national levels.

The following questions will be addressed:
- What has been the role of HIV or NCD champions in mobilizing commitments at national level? What has been their role to mobilize the global health community?
- What are the lessons learned in strengthening the effectiveness of health systems in delivering for chronic conditions? What are the priority approaches and interventions for achieving effective long term treatment and chronic care?
- How can global efforts support national efforts while maintaining country leadership?
- How can countries achieve a better balance across their different health priorities, including maximizing synergies between NCD and HIV responses?

Political commitment makes a difference

In 2001, Heads of State and Government came together in New York to design a united response to the HIV pandemic. After well over a decade of neglect and denial, leaders acknowledged shared concerns not just about the health impacts, but the epidemic's social, economic, and security implications. They committed to a comprehensive plan of action - articulated in a Declaration of Commitment. They made resources available, not enough to solve the problem completely, but enough to start to make a difference. Building on political mobilization, but equally on research, innovation, and the critical partnerships across civil society the world has now begun to reverse the spread of HIV. In some countries the number of new infections has fallen. Globally, new infections have decreased by 19% since 1999. Access to treatment has expanded 13-fold since 2004. Some countries
have made greater progress than others. But what in 2001 seemed to be an insurmountable challenge is now being managed, and the resolve has not withered: in June 2011 the General Assembly adopted a resolution with a political declaration that calls for bold new HIV prevention and treatment targets, as well as for strengthening health systems and integrating HIV and AIDS into broader development.

In much the same vein, there has been global progress on tobacco - again after years of denial. In 2003, UN Member States adopted the WHO Framework Convention on Tobacco Control, a milestone in reversing one of the main causes of CVD, stroke cancers and chronic lung diseases. The convention came into force two years later, and 173 parties, covering 87% of the world's population, have now signed up to it. Steps are being taken to ban smoking in high, low and middle income countries, and tobacco taxes are on the rise in many places. The benefits to public health are already discernible. Much hard work remains to be done on HIV and NCDs, but in both cases, there is evidence that when the leaders of the world decide to tackle a health issue, they can boost progress in countries. Political commitment of global leaders makes a difference.

Many hard lessons have been learnt along the way. There are no silver bullets to address HIV, NCDs, or other health issues such as maternal health. They all require long-term attention, sustained investment, and years of continued effort to keep them high on political agendas and to overcome the fragmentation of the health systems’ responses. This requires perseverance: to make sure that each issue gets the attention it deserve. It also requires building on the significant potential for synergies in responding to issues that present common health challenges. Both HIV and NCDs require strengthened health systems that can deliver universal access to prevention, treatment and chronic care that is effective, continuous and people-centered. Both HIV and NCDs require action beyond the health sector, to tackle their social determinants and the inequalities that they produce. Both need community awareness and mobilization. This is a long term challenge and will require sustained commitment.

**Keep focus by setting targets**

One key to sustaining momentum and focus is to ensure good monitoring and reporting. What gets measured, gets done. By the same tune, what doesn't get measured, doesn't get done.

This means it is important to decide what to monitor. Targets need to be meaningful not just to technicians but also to patient organizations, consumer groups and civil society as a whole. This creates the pressure for accountability that keeps policy makers and providers on track. People are increasingly impatient with the inability of their health systems to deliver services that respond to their expectations and that are able to meet changing needs. As is the case for HIV, the NCD community has to be sensitive to these concerns, and give due place to access and coverage targets, particularly as these relate to chronic care services.

It is also important to be clear about who does the monitoring. When global reporting on HIV started, civil society set up parallel, shadow mechanisms to monitor and report. Over the years, as “official” reporting became more transparent and inclusive, the need for shadow reporting diminished, and overall reporting mechanisms are now much more
inclusive. There is a lesson there: the process of setting targets and designing reporting mechanisms needs to be transparent and inclusive if those targets are to have real impact. If this is done in a way that results in monitoring systems that produce comparable results across the health issues, that will make a huge difference.

**Work within and beyond the health sector**

Neither NCDs nor HIV can be tackled by the health sector alone. Both require a response that cuts across a wide range of government ministries and departments - as well as involving civil society and non-state actors.

This is a matter of common sense. Implementing the tobacco convention, for example, something first advocated for by health professionals, requires – and is now getting - continued action from a variety of government departments including health, environment, customs and excise, education, as well as health workers and consumer organizations. There is much to be learned from the focus of the HIV response on cross-sectoral approaches. Indeed, through the 1990s, the response was shaped by the need to address the multiple factors that increase people's vulnerability and risk of exposure to HIV and obstruct their ability to access treatment and care when they require it. HIV has highlighted the value of high-level advocacy - including the use of champions to focus on key issues relating to stigma and discrimination. Human rights have long been a cornerstone of the response.

So too has social and economic development. Inequities caused by gender and stigma attached to race and sexual orientation not only increase people's exposure to risk, but reduce the likelihood that they will be able to access treatment and care. HIV was first discussed in the General Assembly because it was regarded as a major threat to health, development and security, particularly in sub-Saharan Africa. NCDs are under discussion in New York in 2011 for similar reasons: an upsurge in deaths among people under the age of 60 in low and middle income countries signals a serious threat to the global economy.

The health sector's work is vital. But to leave it to do this on its own, without involving the other government sectors as well as the whole of society in the effort, severely limits the effectiveness and the efficiency of country responses to NCDs and HIV, and reduces the likelihood that it will provide people with the services they need. The experience and lessons learned in promoting multisectoral action for both HIV and NCDs need to be reviewed to inform future policy development.

**People-centered services**

People with HIV and NCDs and the friends and family members who care for them, are uniquely placed to highlight key concerns and needs. They often know what works, and what does not - particularly in terms of promoting healthy behaviours and providing care and support to people with chronic conditions. Indeed, it was people living with or personally affected by HIV who really launched the AIDS "movement" back in the 1980s. Without the active involvement of people living with HIV and their broader communities we would not have seen the success of rapid scale-up of antiretroviral therapy, changes in social norms that have enabled HIV prevention efforts to work, or care to be provided to those affected
who cannot access health services. But it took a long time for the views of people living with HIV to be fully integrated into policy planning.

In framing new global and new national responses to NCDs, it will be important to build on that experience, as well as on the long-standing work of civil society and organizations of patients with NCDs – e.g. those of people with cancer, diabetes or cardiovascular diseases. Unfortunately, such organizations are currently largely limited to high-or middle-income countries although there are recent promising examples, in lower income countries, of nongovernmental foundations that have successfully managed to work in harmony with the public health systems to address the gaps in access to essential health services. It is important to include concerned populations from the very beginning – in designing policies and services, but equally in holding health authorities accountable for producing results. This High-level Meeting has got off to a good start by including civil society in its plenary and round-table sessions. The challenge now is to ensure that participation is extended to all levels of national health policy making, planning and implementation.

We must ensure that our efforts to strengthen health responses meet the needs of the people they are designed to help, in a way that responds to their expectations. It is clear that left to their own devices health systems will not gravitate spontaneously towards health for all. Rather, they tend to develop in ways that contribute little to equity and social justice and fail to get health outcomes commensurate to the money invested by society.

We need to get a better balance between different levels of care. In recent years, there has often been a disproportionate focus on high-end hospitals, and on treatment - to the detriment of primary care and of prevention and health promotion. It is now well understood that the optimal way of delivering a whole set of effective interventions – e.g. the control of hypertension, diabetes, vaccination against cancer causing HBV and HPV, early detection and screening for cancer etc. – is to rely on primary care. A major contribution of 3 by 5 over the last few years has been to show the importance, also for poor countries, of organising people-centered services able to deliver high-quality continuity of care. In a developing world affected by the fragmented vertical programs of the 1990s, this has brought a welcome refocusing on the values of primary health care. At the same time the experience, both with HIV and NCD programs, has highlighted that chronic care, even of high quality, is only part of the answer: efforts to get people to reduce alcohol and tobacco use, cut salt intake and engage in safe sex are much cheaper than paying for treatment later on - and less disruptive to people's lives.

We also need to get a better balance between making sustained progress over the long term and a disproportionate focus on isolated, short-term results. This is particularly the case in low-income countries where donor agencies’ short term priorities may weigh in on national priority setting. For conditions like HIV and NCDs that require life-long prevention strategies and long-term surveillance and treatment, this can be fatal. Where single diseases compete for scarce resources rather than looking for synergies, this contributes to the fragmentation of services, to the frustration of users, and to inefficiencies in the health sector of many countries. Where the various constituencies are made to work together, services can be designed to create synergies in prevention, screening, and care for both HIV and NCDs. This is not just the case for those suffering from HIV and NCDs at the same time – their number is increasing with the markedly improved survival of more than 6
million people on ART. Creating synergies brings benefits for all, as resources for screening, caring, prevention and the like are used more effectively, efficiently and services can focus on people rather than on diseases.

**Universal access**

Having the right type of services is one thing. Ensuring equitable access is another. HIV, NCDs and other chronic conditions often only serve to emphasize the chasm between the haves and the have-nots.

Poor families suffer most when the main breadwinner is sick and can no longer go to work. Even if they can continue to work, much of their salary may be spent on treatment - in some countries, for example, a month's oral treatment for diabetes is likely to cost a week's wages or more.

This is why the 2006 High-level Meeting on AIDS set the ambitious goal of universal access to HIV prevention, treatment, care and support. It links to the wider aim of moving towards universal coverage of a full range of health services - promotion, prevention, treatment, and rehabilitation - that is available to all people - a fundamental requirement for long-term success in tackling NCDs, just as it will be for improving maternal health and reaching the other Millennium Development Goals.

If people are to get access to affordable services and if they are to be protected against the financial hardship disease – acute and chronic, communicable and non-communicable – may cause, a well-functioning health financing system is key. However, in many countries there are three fundamental and related obstacles to providing universal coverage. The first is a shortage of funds: even the richest countries struggle to provide everyone access to every technology and intervention that can improve health and prolong lives. The second is an over-reliance on direct payments at the time people need care - out of pocket, over the counter payments for services. The third is the inefficient and inequitable use of resources – human and financial. Each of these problems is surmountable, and many countries at all levels of income have shown that progress is possible - raising more money through improved tax collection and innovative methods such as taxing mobile phone calls; specific policies on essential medicines and establishing partnerships with civil society and other stakeholders to improve access to essential health care for people with NCDs like cancer; introducing pooled health insurance schemes and taking steps to improve cost efficiency - for example by increasing the use of generic medicines, and by focusing greater attention on health promotion and prevention. Every country will have different needs and different solutions; but every country will need to invest. Wherever possible, the inclusion of both HIV and NCDs into pre-payment and risk-pooling schemes should be considered.

**Inclusiveness and country leadership**

People with HIV and NCDs and the friends and family members who care for them are not the only members of civil society who need to be involved. It will be important to work with consumer organizations, that look after the interests of people as users - of food products, tobacco, alcohol, and of health care products. It will also be critical to involve those who
make and sell such products. Civil society has been a major player in both advocacy and in providing care and support.

The past decade has seen growing prominence of the principle that the development of health systems should be tailored to each country’s unique context. In low-income countries where aid plays a significant role, development work should be founded on country priorities and processes - as articulated in the 2005 Paris Declaration, the 2008 Accra Agenda for Action, and the push for comprehensive country compacts of the International Health Partnership+. This will be key as we move forward in our responses to HIV, NCDs and other chronic illnesses and health hazards.

High levels of political will be required to take the concrete actions required to ensure country ownership, accountability of countries for delivering results, and accountability of the donor community to support countries in their efforts. From a policy maker’s perspective three such concrete actions are:

First, make sure the processes for planning for NCDs, for HIV, and for other health issues are synchronised, aligned, and brought together under the umbrella of a comprehensive national health policy, one that addresses what happens in the private sector as well as through the public sector. The specificities of dealing with HIV and NCDs have to be addressed, but this has to be done within a comprehensive health systems framework: investment in primary care, moving towards universal coverage and promoting health in all policies.

Second, make sure health planning and development planning are aligned and synchronised. As shown by the more recent multisectoral AIDS strategies in an increasing number of countries, this produces quick gains and enjoys increased consensus among development partners and the different constituencies within countries. Conversely, if there is no such alignment and synchronisation, it is unlikely that the multi-sectoral dimension of dealing with HIV and NCDs will be addressed properly and sustained over time.

Third, make sure policy making and planning is inclusive and involves a broad range of relevant stakeholders. It is needed to engineer synergies and efficiencies, and to ensure that action responds to societal demand. And it is needed to ensure that the response is anchored strongly in a nation’s priorities, and remains vigorous and sustainable. We should not just have one plan, one budget and one monitoring and evaluation framework for each single disease: we should have one comprehensive plan, one comprehensive budget and one comprehensive M&E framework that does justice and brings balance to the different priorities a country has.

Experience with HIV and NCD programmes shows that there are significant gains to be realized by developing common approaches. A health system that would deal with HIV but ignore NCDs would forfeit all credibility, but so would one that would deal with NCDs and neglect HIV. Policy makers have the arduous task to find an adequate balance between competing priorities – a balance that cannot neglect either NCDs or HIV, and has to deal with other important health issues as well. With limited resources and increasing demand this is always a daunting responsibility. That makes it even more important to build on the potential for synergies in designing the response to HIV and NCDs. Experience with HIV and NCD programmes shows that many of the challenges are common: the challenge of
promoting health literacy and delivering preventive as well as chronic care; the challenge of mobilizing society across sectors to deal with their social and environmental determinants of these diseases; and the challenge of reaching the poor and those excluded from care and disproportionately affected by these diseases. Such common challenges obviously require a common response, and above all common political commitment at the highest level in each country.

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