



## Meeting recommendations

### **aids2031 Programmatic Response Working Group Constituency Consultation Oslo, 20-21 November, 2008**

The Programmatic Response Working Group aims to assist the broader aids2031 project in identifying key programmatic actions that should be taken to influence the epidemic's course over the next generation. To inform this effort, the working group seeks to take into account community-based perspective and programmatic experiences. This impulse derived not only from a recognition that bold community leadership and action will be essential to a sustainable and optimally effective long-term response but also that important evidence and perspectives are uniquely within the possession of the communities most heavily affected by the epidemic.

In October 2008, the aids2031 Programmatic Response Working Group approached leaders from a range of constituent groups<sup>1</sup> outside the United Nations system to seek their views on the following three questions:

- *What has been successful in the current response to the HIV/AIDS epidemic and what do you think is critical to keep for a good response in the long-term?*
- *What are the new ways of thinking required to effectively address the challenges you are facing, and how would you address them?*
- *What kind of leadership is required to shape and guide this new response and how can your group contribute?*

#### **Oslo Meeting**

Feedback on these questions, a summary of which is attached served as a starting point for further consultation with constituent focal points at a 20-21 November 2008, meeting in Oslo, hosted by the working group. The purpose of the meeting was to identify recommendations for strengthening and sustaining an effective programmatic response and for identifying strategies for meaningful and ongoing involvement of communities in the implementation and monitoring of recommended programmatic actions.

During the meeting the constituency focal points were asked to identify crucial elements in the response to the AIDS epidemic that would need to be implemented now in order to successfully respond to the epidemic in the future. The group agreed during the two-day meeting to examine the following 15 issue categories:

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<sup>1</sup> The constituency groups include: armed forces, children, child soldiers, commercial sex workers, faith-based organizations, health workers, intravenous drug users, men who have sex with men, migrants, parliamentarians, people living with HIV, prisoners, women/battered women and young people.

1. Accountability
2. Access to HIV/AIDS services for health-care providers
3. Bad strategies
4. Challenging churches, faith-based communities and traditional healers
5. Community integration, mobilization and empowerment
6. Consultations among different stakeholders to create formal structures
7. Eradicating HIV/AIDS stigma
8. Equalizing power structures in decision-making
9. From access (to services) to quality services
10. Gender-based human rights approach
11. Grassroots movements
12. HIV, youth and children
13. Redefining HIV Communications
14. Results
15. Structural programmatic leadership capacity development

## Priority Themes

From the list of key issue categories identified by the group, participants were asked to select areas that would need to be dealt with as a matter of priority during the workshop and to develop recommendations for future action. The following five priority themes emerged from these discussions:

1. **Children and youth**
2. **From access to quality services — how to handle “bad” strategies in the response**
3. **Grassroots mobilization and community development**
4. **Redefining HIV communications**
5. **Results and accountability**

For each of these priority themes, participants surveyed current needs, programmatic barriers or impediments, and the state of the response. Participants also issued recommendations to strengthen the programmatic response in each of these areas.

## 1. Children and youth

### Situation analysis

- **Youth are heard but not listened to:** Although youth are often invited to participate in discussions on the response, their input is not always taken into account in decision-making processes or programme design.
- **The evolving needs of children, in particular, are often not taken into account:** Children living with HIV face markedly different circumstances, prospects and challenges than in the past. Earlier in the epidemic, HIV-positive children who were perinatally exposed tended to die soon after birth. In 2008, more and more children are surviving into adolescence and must come to terms with a range of issues. Programmatic responses have frequently failed to take into account the rapidly evolving needs and circumstances of HIV-infected children.

- **Non-youth-friendly programmes:** School-based programmes are meant to target youth, but these programmes are not always youth-friendly. Moreover, the formal creation of these programmes does not always lead to effective implementation on the part of teachers. Ineffective or unsuccessful programmes are often perpetuated. In addition, programmes for out-of-school youths are lacking.
- **Non-specialized programmes:** Programmes often focus on youth as a whole, ignoring the fact that young people at risk or affected by HIV are extraordinarily diverse. Young people are differentiated by diverse life experiences, life skills, access to services or other resources, and the magnitude and nature of HIV-related risks.

## Recommendations

- **Better use of communications tools:** Mass communication programs, including the internet, should be used more widely to make the public at large, (including parents, in particular) aware, on a regular basis, of the issues that children and youth face and also to communicate with youth. World AIDS Day is not enough.
- **Life-skills:** An increasing, yet greatly insufficient, number of HIV-positive children are on treatment and now confront a range of new challenges and special needs—particularly as they make the transition to adolescence. Life-skills programmes that are delivered through innovative means, in school and in out-of-school settings, are urgently required. Teachers should be trained in how to pass information on to students in a more effective manner. Outside of schools, parents should have access to more information on life-skills for youth; immunization programmes offer one such venue.
- **Capacity building:** Developing the capacity of youth leadership to engage in policy dialogue and to influence policy and programmatic decisions is a prerequisite of effectively harnessing the unique perspectives of this constituency.
- **New ways of thinking require new systems:** Although the UN system will remain a key player in strategic planning, programmatic responses and technical support regarding children and young people, Innovative thinking, ownership of the response, and leadership are also urgently needed from players outside the UN system.

## 2. From access to quality services- how to handle 'bad' strategies in the response

### Situation Analysis

- **Legislative environment:** A growing number of countries are implementing laws that criminalizing the “knowing” or “negligent” transmission of, or exposure of another to, HIV. Mandatory testing policies are in place in different sectors and settings, and many countries impose restrictions of the ability of HIV-positive people to travel. In addition, most countries criminalize engaging in or soliciting sex work, having sexual relations with someone of the same gender, using drugs or possessing drug-related paraphernalia. In some settings, laws penalize groups or individuals that serve people who use drugs.
- **Gender inequities:** Institutionalized gender-based discrimination is in place in many parts of the world. For example, legal frameworks in many countries do not recognize, or otherwise place limits on, women’s right to own or inherit property.
- **Stigmatizing social environment:** Negative social attitudes towards people living with, or at perceived elevated risk of, HIV – often accompanied by overt discrimination – prevail in many parts of the world. HIV-related stigma may manifest itself in individual encounters, within families or households, at the community level, or in legal frameworks and international conventions. In addition to people living with HIV, highly stigmatized groups may include (prisoners, men who have sex with men, transgenders, drug users, migrants and others).
- **Lack of awareness, recognition and enforcement of human rights:** In many communities, insufficient knowledge exists regarding human rights. Where recommended human rights protections are theoretically in place, many individuals lack the means to enforce or protect their rights. Enforcement of human rights protections is often especially inadequate with respect to marginalized groups at greatest risk of HIV infection.
- **Unequal access to comprehensive, relevant, rights-based HIV/AIDS services:** Populations most affected by the epidemic are often not included in the development and implementation of programmes or policies that affect them. Rights-based interventions are lacking for numerous groups, including but not limited to men who have sex with men, transgender individuals, and groups that are especially vulnerable to human rights abuses, such as child soldiers.

### Recommendations

- (a) **Mobilize global bodies**
- **Improve synergy and coordination among UN agencies to address criminalization**
  - ✓ The UN system must create more solid synergies by sharing information and better collaborate on criminalization issues at all levels.

- ✓ Leading international organizations should more openly speak out against criminalization of HIV transmission or exposure. Such organizations should be involved in collaborative efforts to forge coalitions to oppose and reverse such laws.
- ✓ The Office of the High Commissioner on Human Rights should take a tougher stand against HIV-related criminalization and partner more closely with UNAIDS.
- **Encourage UNAIDS to take a more proactive approach in opposing criminalization and other human rights abuses**
  - ✓ UNAIDS should actively advocate against criminalization with individual member states and other partners. UNAIDS' general opposition to criminalization should be translated into bold leadership and focused intervention to address potential human rights problems as they arise.
  - ✓ Having developed general guidelines on criminalization, UNAIDS should now actively work with member states and other agencies and partners to ensure implementation of these guidelines by Member States.
  - ✓ The new Executive Director of UNAIDS should oppose the version of the 'HIV and AIDS Sex Work Guidance Note' previously released. UNAIDS should resist pressure from Member States or other organizations to 'fight prostitution' and should instead support programmes and policies that advance sound, evidence-based HIV prevention for sex workers.
  - ✓ UNAIDS should collaborate with affected communities to develop policy and programmatic frameworks and strategies that not only promote service access but also service quality.

**(b) Encourage funders and donors to be more proactive in opposing criminalization and other human rights abuses**

- Civil society and international organizations should encourage donors to support anti-criminalization work.
- Bilateral AIDS agencies should adopt guidelines that state that they will not provide aid to countries that have laws in place that criminalize HIV transmission or exposure.
- Fund groups that take a rights-based approach to HIV; reach out to groups that are doing legal work on HIV; and fund populations that experience stigma to run stigma and discrimination campaigns — fund those groups directly affected by their HIV-epidemic

**(c) Introduce strategies at the national level**

- With the support of UNAIDS and bilateral donors, civil society organizations should develop and implement strategies to oppose efforts to criminalize HIV transmission or exposure. Potential useful strategies include public education campaigns explaining why criminalization of HIV is counterproductive and

advocacy initiatives focused on parliamentarians to encourage them to oppose such legislative initiatives or to repeal such laws if they are in place.

**(d) Work with policymakers and programme implementers to promote a rights-based response**

- Innovative anti-stigma campaigns should target individuals and groups who may be prone to stigmatize and discriminate (e.g. health workers, traditional healers).
- Workplaces should be governed by clear and explicit HIV non-discrimination policies, including mechanisms for disciplinary actions against those who stigmatize or discriminate against people living with HIV.
- Focused HIV education curricula should be developed for key groups, including but not limited to religious leaders/faith-based providers, health care providers, etc.

**(e) Give civil society a greater voice**

- UNAIDS technical support teams should provide guidance and develop mechanisms for reporting on HIV criminalization
- UNAIDS should strengthen its work to support implementation of the “Three Ones,” focusing particular attention to efforts to give a stronger voice to civil society in the development, planning, implementation and monitoring of national policies and programmes.
- Using lessons learnt from the successful the UNAIDS/Global Fund *Travel Restrictions Committee*, UNAIDS should develop a coordinated collaborative effort with governments and civil society against criminalization.

**(f) Expand the research agenda**

- More research is required into the causes and sources stigma in different communities. Additional research is also required to identify and validate new programmatic strategies to reduce HIV-related stigma.

**Additional suggestions:**

- UNAIDS and other stakeholders should make better use of the Universal Human Rights Treaty to address HIV-related stigma and discrimination. Anti-stigma work should become part of a human rights-based response.
- New trainings models should be developed to promote integration of community services in policing, incorporate social dimensions of HIV in health workers training, and integrate issues of human rights, HIV, drug use and tuberculosis in training of prison guards and other prison workers.
- Mechanisms should be established to promote collaboration, cross-learning and collective action among diverse constituencies affected by HIV. In particular, such collective action is needed to address criminalization, mandatory testing, and other problematic aspects of the response. Such mechanisms could also promote greater

awareness of linkages between different constituencies; for example, opposition to mandatory testing should be embraced by the broader AIDS advocacy community and not regarded as a specific concern of individual groups, such as sex workers, prisoners or asylum seekers.

### 3. Grassroots mobilization and community development

#### Situation analysis

- **Communities are the best change agents:** People infected and affected by HIV are best placed to make change happen, because they are familiar with communities' specific needs.
- **Shortcomings of community-based programmes:** Grassroots community groups lack capacity and resources and are therefore not empowered to participate effectively in the HIV response. In addition, some community-based programmes are not inclusive; do not address sensitive issues, such as stigma and discrimination; and are difficult to sustain.

#### Recommendations

- **Strengthen the sense of belonging:** To boost community ownership, political readiness and capacity, diverse communities should join hands with each other to forge larger networks to increase impact and share experiences and lessons learnt.
- **Change attitudes:** Advocacy efforts to promote social change must be adapted to cultural traditions and local belief systems.
- **Create alternatives:** Community-based approaches should be inspiring rather than merely instructive.

### 4. Redefining HIV communications

#### Situation analysis

- **Potential information overload:** HIV-related communication efforts should be reevaluated to identify what is working and what needs to be changed. For example, celebrity campaigns, a common feature of HIV communications, should be evaluated to determine if they are effective. Likewise, standard information/education/communications interventions, which have been shown to improve HIV-related knowledge, should be studied to assess the degree to which they change behaviours.
- **Mode of communication:** In some settings and populations, widespread illiteracy requires that communications efforts focus on channels other than printed matter. In addition, in remote regions of the world, word-of-mouth or radio may be the only effective means of communication.

## Recommendations

- **Adapt communication strategies to local needs:** Communications strategies should be adapted to effectively reach different target audiences, such as donors, politicians, the general public, remote communities and others. For example, youth-oriented communications should use relevant technologies and appropriate idioms.
- **Redesign information/education/communications material:** IEC materials should integrate evidence-informed strategies to change behaviours. Grassroots organizations should be involved in the process of evaluating IEC strategies and defining the communications techniques to be used for particular focus populations.
- **Include communications in programming:** In designing an HIV/AIDS programme, the communications aspects should be included from the outset because they can be decisive in making or breaking a programme.
- **Take a brand-driven approach to engaging young people:** The promise and potential of drawing on the experience of the corporate sector to create viable brands should be examined and studied for HIV-related communications. Branding, such as Nike's 'Just Do It' campaign, could serve to inspire hope and a sense of collective ownership of ambitious HIV goals. Brand identity is important in youth culture and can be communicated through electronic media that are widely used by youth, even in low-income settings. A brand-driven approach may reduce stigma and discrimination and, coupled with measures to increase empowerment, may lead to a ground swell of public support for more effective national responses. This approach, in turn, would alter the political acceptability of addressing what is still sometimes perceived to be a controversial issue in all too many settings.

## 5. Results and accountability

### Situation analysis

- **Disconnect between data collectors and interpreters:** Community members are often asked to collect information but tend not to be provided with feedback on the implications of the information provided.
- **Lack of transparency with respect to resource availability:** In some communities, it is not known how much money has been made available for HIV/AIDS programming. This lack of transparency makes it difficult to hold programme implementers accountable.
- **Duplication of effort:** The multiplicity of funding streams creates the potential for duplication and waste.
- **Lack of accountability of the Country Coordinating Mechanism (CCM):** Questions exist in some countries regarding the accountability of the CCM to

presumed programme beneficiaries. In some countries, there is a lack of clarity regarding the function and aims of the CCM.

## Recommendations

- **Strengthen accountability mechanisms**
  - ✓ Proper mechanisms to monitor and evaluate financial expenditures must be implemented. Resource allocations should in all cases be based on documented evidence of needs and impact. Financial resources must in all cases reach the grassroots level where they are needed..
  - ✓ Sanctions should be imposed when countries fail to perform adequately.
  - ✓ Civil society must be regarded not merely as a watchdog, but as a critical partner to be involved in planning, implementation, monitoring and evaluation.
  - ✓ Donors should earmark funds for monitoring and evaluation
- **Introduce a whistle-blowing system:** A mechanism for whistle blowing must be put in place to improve responses, including inbuilt safeguards for whistle blowers. In addition, the media could be better used to pressure partners and NGOs to be accountable.
- **Pursue mutual, values-led accountability:** A normative approach to accountability should be adapted, based on the experience of the 'Wakeup Pune Coalition' involving a range of constituencies, including young people. In this small coalition, partners agree to undertake specific activities to achieve common goals. Partners meet on a quarterly basis and on the basis of *trust* and *critical self-reflection*, report to their peers on progress achieved, the rationale for any deviation from the plan, and agreement on any remedial steps that need to be taken. If coalition partners are not pleased with a partner's contributions, the partner can be asked to leave the coalition. This grassroots initiative enables partners to ensure mutual accountability for progress on country-led efforts to achieve universal access or MDG 6.

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**aids2031 Programmatic Response Working Group  
Constituency Consultation  
November 20–21, 2008  
Oslo, Norway**

**Annex 1. Participants List**

**Siam Arayawongchai- Thailand**

The Purple Sky Network

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Siam is head of the The Purple Sky Network (PSN) which is a network of HIV interventions among MSM in the Greater Mekong Sub-region (GMS) formalized in July 2006. The network covers countries of the GMS, namely, Cambodia, Laos, Myanmar, Thailand, Vietnam and the southern provinces of Yunnan and Guangxi in China. The primary goal of PSN is to reduce infections among MSM in the GMS as well as to promote for better care and treatment. Funding support for the secretariat comes from the United States Agency for International Development/Regional Development Mission/Asia.

Prior to the establishment and after its formalization, a number of achievements have been made within PSN. These include: inclusion of MSM in all national (provincial in the case of China) AIDS plans within the GMS (no inclusion prior to PSN formation), establishments of national/provincial technical working groups to help drive the efforts locally, better coordination by stakeholders and visibility of MSM in all the countries. Two countries, Cambodia and Thailand, have a specific national MSM strategic plan/operational plan. PSN has also become a platform for regional collaborations.

The Regional Coordinating Secretariat with Jack Arayawongchai as the coordinator has been providing the network support in three key areas- administrative support (daily operations, running of the secretariat, policy), technical support (identification of technical needs and facilitation of technical assistance needed, establishment of national/provincial coordination mechanisms) and network maintenance and communication support (promotion of communication, identification of communication strategies, regional meetings and networking opportunities, experience and lessons learned sharing).

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Eddy Beck was born in Indonesia of Dutch parents. At the age of 15, he moved from the Netherlands to Melbourne, Australia. There he completed his medical degree after which he moved to the United Kingdom for postgraduate work. Ever since he began his public health training in 1986, Eddy has been working in the field of HIV. He has been involved in different aspects of HIV-related work and is currently working in the Evidence, Monitoring and Policy Department of the UNAIDS Secretariat in Geneva.

## **Kent Buse- UK**

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Kent Buse is Senior Advisor on Policy and Strategy at UNAIDS. He works on issues around AIDS exceptionality, AIDS transition, service delivery within the context of enhanced programmatic support, and political analysis of national responses. Kent taught at Yale University and the London School of Hygiene and Tropical Medicine and spent the past three years at the Overseas Development Institute, London. He has advised a range of multilaterals, bilaterals and global health initiatives. Kent is a health policy analyst with a particular interest in the politics of decision-making and has published widely on global health governance, global health partnerships, aid architecture and health policy-making.

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Caitlin is advocacy & outreach officer at aids2031. She previously worked for the Global Youth Coalition on HIV/AIDS, where she trained young AIDS activists from around the world in political advocacy, fundraising and project management, and did international advocacy around youth issues. In Accra, Ghana, Caitlin was the 2004 World AIDS Week Director for the West Africa AIDS Foundation, where she oversaw the creation of an AIDS-awareness song, music video and concert. She served as the Marketing Director for the NYC-based nonprofit NYC Student Initiative for AIDS, and was a member of their Board of Directors for two years. Caitlin also interned with Médecins Sans Frontières Access to Essential Medicines Campaign.

She is the creator of the Talking With Pictures digital photography exchange project, and has written for the Village Voice, Brownstone Magazine, and the Journal of International Law & Politics at NYU. Caitlin graduated from New York University with an honors B.A. in History and Comparative Literature. Her senior thesis received the Kwame Yehboah Daku award for Achievement in African History.

## **Anna Louise Crago- Canada**

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Anna-Louise has spent a large part of the last 15 years as a leader in the Montréal sex worker community and as an HIV activist. In 2005, she and the other team members at Stella, Montreal's center by and for sex workers, organized a meeting of over 250 sex workers from around the world. In 2006, she co-coordinated sex worker activities at the International Aids Conference. Anna-Louise currently works with male, female and trans sex workers organizing for the recognition of their human and labour rights in Eastern Europe and Central Asia through her collaboration with the SWAN network ([www.swannet.org](http://www.swannet.org)).

She also works for the Open Society Institute researching and documenting human rights abuses against sex workers in southern Africa. She is the principal author of "Rights Not Rescue: Human Rights Abuses Against Sex Workers in Botswana, Namibia and South

Africa” and the author of “Our Lives Matter: Sex Workers Unite for Health and Rights”. Anna-Louise is part of the Global Working Group on HIV and Sex Work Policy.

## **Sarah Des Rosiers- Canada**

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Sarah is Program Officer at UNAIDS and has previously worked at the World Health Organization on a pooled procurement project for the East African Community to improve access to essential medicines in the region. She has worked in community health projects in Tanzania and holds a Masters degree in International Health Policy from the London School of Economics.

## **Muzi Dlamini- Swaziland**

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Muzi is a professional nurse and midwife with vast working experience in the Swaziland government for the Ministry of Health and some missionary hospitals as a nurse midwife. He has also worked for a leading non governmental organization coordinating HIV/AIDS Projects. Currently, he is the coordinator/Project Manager for The Wellness Centre for Healthcare workers which I have been involved with since its inception in 2006 and is also involved in HIV/AIDS Testing and Counseling as a master trainer.

The Swaziland Wellness Center for Health Workers aims to strengthen health systems through the provision of quality comprehensive health services for all cadres of health care workers and their immediate families. It is responsive to their needs, managed by nurses and supported by inter-sectoral partnerships. Services provided include: HIV Testing and counseling, treatment of opportunistic infections, TB Screening and treatment, Stress and burn out management, Post exposure prophylaxis, Antenatal care, Healthy life styles trainings.

## **Christine Ebrahimzadeh- Austria**

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Christine is Senior Advisor at UNAIDS. She previously worked at the International Monetary Fund in Washington, DC. As Assistant to the Director of External Relations, her main task was to advise and assist in restructuring the department so as to enhance the efficiency of work processes, allowing for more effective and targeted internal and external communications. She has worked for several other international organizations (UNICEF Uganda, UNICEF Gabon, the European Bank for Reconstruction and Development and the Interamerican Development Bank) in various capacities (Project Evaluation Officer, Public Affairs Officer, Senior Editor and Production Manager). Christine holds a Master’s Degree in Business Administration from Dartmouth College and a Master’s Degree in Development Economics from American University.

## **Renata Ellingsen- Czech Republic**

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Renata is Program coordinator Europe and Central Asia at Norwegian Church Aid in Norway and in charge of HIV programming.

## **Raoul Fransen dos Santos- Netherlands**

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Raoul Fransen has been involved in a wide range of programs supporting people living with HIV and AIDS globally, since he was diagnosed HIV-positive at age 15. He is co-founder of Young Positives, an international network of young people living with HIV&AIDS, which brings together young people living with HIV and their experiences and advocates for their rights. Young Positives' aim is to come to better ways to improve access to treatment, reduce stigma and discrimination and to promote the greater involvement of young people living with HIV in policy and decision-making forums. Young Positives is affiliated to the Global Network of People Living with HIV/AIDS (GNP+).

Raoul addressed the 2004 International AIDS Conference as a plenary speaker and acted as the interim International Coordinator and CEO of GNP+ in 2006. As a volunteer, he has been involved since 1996 in setting up numerous programs providing antiretroviral treatment and projects supporting orphans and vulnerable children in sub-Saharan Africa. He studied Tropical Medicine and Health Sciences at the University of Maastricht and holds a Masters degree in Public Health. Before joining the ICSS team, he also worked at the Dutch NGOs Aids Fonds and STOP AIDS NOW! focusing on young people's issues and access to HIV treatment & care.

Raoul is currently a policy officer at International Civil Society Support and coordinates the LAASER Roundtable Process on HIV treatment, a five year, €15 million program around HIV Drug Resistance Surveillance and Coordination of Civil Society's Response to HIV.

## **Mike Isbell- United States**

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Educated as a lawyer, Mike Isbell became engaged in the AIDS response in the mid-1980s, when he filled a legal challenge to the U.S. government's policy of mandating the testing of all participants in a government-supported vocational training program for young people, and excluding all those who tested HIV-positive. (The government changed its policy as a result of the lawsuit.) Mike headed the AIDS law project of Lambda Legal Defense and Education Fund, the oldest gay rights legal organization in the U.S., and was also director of advocacy and public policy for Gay Men's Health Crisis, the world's first community-based AIDS service organization in New York City. During the Clinton administration, he was a member of the Presidential Advisory Council on HIV/AIDS. For the last decade, he has worked as an independent consultant in public

health policy, advocacy planning and communications, and organizational planning and development. He is senior advisor for the aids2031 initiative.

## **Jantine Jacobi- Netherlands**

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A health systems specialist and physician, Jantine Jacobi pursued advanced studies in child development and preventive health care of infants, applied epidemiology, gender and reproductive health and health systems management at universities in The Netherlands, South Africa, the United Kingdom and the United States. Her international career started in Indonesia, where she worked with a local NGO on child health. In 1993, she joined WHO and worked in Nepal, Zambia and Namibia on Child health, Reproductive Health, and AIDS respectively. She was involved in policy formulation and the development of strategies, guidelines and services. She was UNAIDS Country Coordinator for Ukraine, Moldova and Belarus and became the Senior Advisor, Country Support for Treatment and Care, facilitating country-level scaling up, in collaboration with WHO.

## **Sylvie Jacquat- Switzerland**

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Sylvie Jacquat joined the World YWCA as Communication Assistant in 2007. Born and raised in Switzerland, Sylvie holds a university degree in history, journalism and social communication. Sylvie worked overseas for three years serving in the humanitarian field in Serbia with Handicap International (2003-2004), in Sudan with a Sudanese NGO called Sudan Social Development Association – (SUDO) (2004-2005) and Colombia, again with Handicap International (2005-2006). Sylvie is also currently studying for a graduate education in communication and public relations at SPRI Institute in Lausanne, Switzerland.

The World YWCA is a global network of women leading social and economic change in 125 countries worldwide. It advocates for peace, justice, human rights and the environment, and has been at the forefront of raising the status of women for over a century. The World YWCA develops women's leadership to find local solutions to the global inequalities women face. Each year, it reaches more than 25 million women and girls through work in 22,000 communities. The World YWCA is a volunteer membership movement inspired by Christian principles and a commitment to women's full and equal participation in society. It is inclusive of women from many faiths, backgrounds and cultures. Since 1855, the YWCA is at the forefront of empowering women and girls who advocate for their rights and lead social, political, economic and civic change. The main priorities of WYCA are around Women's health and HIV and AIDS; human rights of women and children; world peace with justice; sustainable development.

## **Tale Kvalvaag- Norway**

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Tale Kvalvaag is working as a senior adviser at Norad's Global Health and AIDS Department. Previously she worked as a senior adviser at Norad's Evaluation Department. Before joining Norad she worked as an evaluation officer at Sida's Evaluation Department. She has mainly been responsible for thematic evaluations, as well as evaluations of strategies and policies. From 1998 to 2002 Kvalvaag worked for UNAIDS in Geneva (headquarters) and Guatemala (regional office), where she was involved in monitoring and evaluation of National Strategic Plans for HIV/AIDS. Kvalvaag holds a master's degree in sociology from the University of Oslo.

## **Lars O. Kallings- Sweden**

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Professor Kallings, a Swedish national, was the founding President of the International AIDS Society in 1988. As its Secretary-General from 1994 to 2002, he played a key role in shaping the IAS as the world's first global society for scientists and health care workers committed to the prevention and treatment of HIV.

Professor Kallings was appointed by the UN Secretary-General in May 2003. Engaged in the AIDS response for over 20 years, he has held positions including adviser to the World Health Organization, Chairman of the Global Commission on AIDS and Senior Adviser to the Global Programme on AIDS on Scientific and Policy Affairs. He is currently honorary Chairman of AIDS Accountability International. Lars is UN special envoy on HIV in Eastern Europe.

## **Christoforos Mallouris- Cyprus**

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Christoforos Mallouris is Director of Programmes at GNP+ where he steers the GNP+ programme platforms of Sexual and Reproductive Health, Human Rights, and Empowerment. Christoforos Mallouris was born in Cyprus and started his career as a Scientist in Astrophysics. Most recently, he was a member of the Section on HIV and AIDS at UNESCO Headquarters, Paris. There he was specifically involved with HIV and AIDS education programmes, including school-centred care and support, support for and by positive educators, and the educational needs of positive learners. In addition, Christoforos Mallouris was involved with UN+, the UN system HIV-positive staff group, as a member and Chair of the Advisory Group.

The Global Network of People living with HIV/AIDS (GNP+) is the only worldwide network representing all people living with HIV. GNP+ advocates to improve the quality of life of people living with HIV. Its work is based on a policy platform that promotes global access to HIV care and treatment, ending stigma and discrimination, and greater and more

meaningful involvement of people living with HIV in decisions that affect their lives and their communities.

### **Godfrey Malembeka- Zambia**

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Godfrey is director of Prisons Care and Counseling Association, a Prisons based non-governmental and non-profit making organization existing under section 7(I) of the Societies Act. The organization was founded and formed by an ex-convict in 1997 and was duly registered on the 29<sup>th</sup> of April, 2005 under the Registrar of Societies pursuant to and in accordance with the provisions of the Societies Act CAP 199 of the laws of Zambia. PRISCCA is among a few NGOs in Zambia exempted from all kinds of government Tax revenues by the Ministry of Finance and National Planning.

The organization is also given comprehensive authority by the Ministry of Home Affairs and the Prisons Command to operate in all the 86 prisons in Zambia. PRISCCA was formed to supplement/ compliment governments' efforts in rehabilitating prisoners and prisons and to: promote and encourage good health life styles among inmates, prison staff and the surrounding communities; promote and encourage Academic Education, Entrepreneurship and Vocational skills training and help reintegrate ex-prisoners back into Society.

### **Rachel Makunde- Tanzania**

Plan Tanzania

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Rachel is a Medical Doctor with a Masters Degree in Tropical Medicine, which she obtained in Liverpool School of Tropical Medicine in 1997. She got involved with HIV while working as a clinician in a government hospital where she participated in international forums on Infectious diseases in Manchester, Copenhagen, the Netherlands and in East Africa; Kampala and Nairobi. In 2003, she joined an NGO; Dutch International Organization where she was working with local communities in areas of health, water and sanitation before joining Tanzania Public Health Association. She joined Plan International in August 2007. Her responsibility in Plan is to provide coordination support to health programs for four Program Units in three regions namely; Dar Es Salaam, Coast and Morogoro until recently when I was awarded a new Senior position of Program Unit Manager for Dar Urban.

### **Guelord Mbaenda- Democratic Republic of Congo**

Action des jeunes pour le Développement Communautaire et la Paix (ADECOP)

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Guelord is the executive director of ADECOP, Action des jeunes pour le Développement Communautaire et la Paix (ADECOP), an NGO founded in 2002 in the region of Goma, Democratic Republic of Congo. He has been a great advocate for human rights of

children in the region of Goma in the DRC, and has been involved in the reintegration of child soldiers and the mainstreaming of HIV programs for young ex-combatants.

ADECOP was created mainly to promote, as part of post war community renewal efforts, the recognition of children and youth rights protection and participation, as a widespread cultural acceptance of exclusion and violence as well as the lack of appropriate policies to address this have led to systematization and institutionalization of violence against children and youth in the North Kivu Province, especially in Goma, Masisi and Rutshuru Areas. The vision of ADECOP is to promote understanding of children and youth rights, attain violent free and protective legal, social, cultural, economic and social environments as well as establish firm foundations for community and State rebuilding through children and youth's empowerment. Its main activities have been focusing on participation and leadership; culture, tradition and religion in their relationship to children and youth's rights; child Soldiering, HIV/Aids, Small Arms; children and Young People Building Peace; Human Rights, Governance and Child Issues.

## **Vanessa John Mlawi- Tanzania**

### **Plan Tanzania**

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Vanessa is 17 years and is currently attending her secondary school education in Dar Es Salaam (Form five) after two years of successful completion of the secondary education, will join the University. Prior to joining the current school, Vanessa was schooling in another school which is located within Plan supported area about 35 kms from Dar Es Salaam. Vanessa is a peer educator on comprehensive reproductive and sexual education since 2002. She is a member and a leader of a youth club known as "TUSEME" in her previous school and still maintains her membership in the same club in the current school. The club's philosophy is "Let us Speak out" which is a translation of "TUSEME" in the local language. The communication strategy used in the club is through debates on reproductive and sexual education, singing, role-plays, dancing, drawing and paintings. These activities demonstrate how students themselves can visualize their world in terms of imaginative and creativity. Fine arts and developing health promotion materials (newsletters and School magazines), life skills studies are other activities being done in TUSEME club. The idea to start the youth club was initiated by a group of teachers to support programmes at schools that help students to explore problems related to HIV and AIDS, reproductive health and other social and academic issues affecting students. Since then, Vanessa has been maintaining an active role in mobilizing youth in other schools and at the church; she is a Sunday school teacher (religious session for children) in her area.

In 2005, Plan Tanzania supported Vanessa to represent youth in a meeting in Uganda. The purpose of the meeting was to discuss HIV response strategies and involvement of youth in formulation of new strategies, policies and implementation of prevention interventions. In addition, in this year while attending the AIDS 2008 International conference in Mexico, she was selected to be a youth spokesperson and she participated in a press conference whereby she gave a testimony of living with AIDS patient (her aunt) since she was 9 years. Her talk related her knowledge on stigma before being a peer educator and after being a peer educator.

## **Joseph Kasozi Muyomba- Uganda**

Parliament of Uganda

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Joseph is a lawyer by profession and a young parliamentarian working on HIV issues in Uganda. He has also served as Secretary of Health of the Masaka District Local Government.

## **Sigrun Møgedal- Norway**

Norwegian HIV/AIDS Ambassador

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Sigrun has been the Norwegian HIV/AIDS Ambassador since 2005, working with the She holds a medical degree and works in the areas of professional and diplomatic engagement in the global health and HIV/AIDS response, partnership development, global and national health architecture and reform and foreign policy regarding global health. Dr. Møgedal is currently a board member of the Global Fund to Fight AIDS, TB and Malaria, the Global Health Workforce Alliance and UNITAID and a two-term board member of the Global Alliance for Vaccines and Immunization. Previously she served as Senior Policy Advisor to the Executive Director of UNAIDS, the State Secretary of International Development for the Government of Norway and held various posts in health-care organizations, with long-term service in Nepal.

## **Justin Parkhurst- UK**

aids2031

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Justin Parkhurst (B.S., M.Phil, D.Phil) is a Lecturer at the London School of Hygiene and Tropical Medicine. He is a multidisciplinary social scientist who conducts research on HIV/AIDS with a focus on policy and prevention, primarily in low income settings. He has undertaken investigations of Uganda's HIV success and the interpretations of the evidence around that success story, and on the PEPFAR strategy for HIV prevention internationally. He has written on issues of policy for prevention, including the need to increase attention to the structural factors shaping risk behaviors. He sits on the Social Drivers advisory group for AIDS2031.

## **Himakshi Piplani- India**

Global Youth Coalition on AIDS

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Himakshi Piplani, 20, is a youth activist, currently pursuing her law degree from Symbiosis Law School in Pune, India. She is working with Global Youth Coalition on HIV/AIDS (GYCA) as Regional Focal Point for South Asia. Her interest in HIV/AIDS and related issues developed in early 2005 while researching for an article on sexual violence against children in the war-torn Darfur region, as well as the International Inter-Faith Conference on HIV/AIDS organized by National AIDS Control Organization (NACO) of India, which prompted her to do further research on the HIV/AIDS scenario in India and

abroad. As the final project for GYCA's Political Advocacy e-course, she developed an advocacy campaign plan based on increasing young people's access to HIV/AIDS related information, education and communication services.

In 2006, she led a team of youth volunteers to review the government's commitments at UNGASS on HIV/AIDS and subsequently wrote the India Youth Shadow Report for UNGASS + 5 Review as a part of GYCA's National Research for UNGASS + 5 review process, and attended the Youth Summit UNGASS as a youth representative with full funding provided by UNICEF. In 2007 she presented a paper on Impact of criminalizing homosexuality on transgender community in India, at the 4th Asia Pacific Conference on Reproductive and Sexual Health held in Hyderabad. She also served as the GYCA National Focal Point for India that year.

### **Thabo Sephuma- South Africa** Ecumenical Advocacy Alliance

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Thabo is HIV and AIDS Campaigns Officer at the Ecumenical Advocacy Alliance in Geneva, Switzerland. The Ecumenical Advocacy Alliance is an international network of over 100 churches and church-related organizations committed to campaigning together on common concerns. Current campaigns focus on HIV and AIDS and Global Trade.

### **Michel Sidibe- Mali**

UNAIDS Deputy Executive Director of programmes and United Nations Assistant Secretary General

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Mr. Sidibe's career in global health and development spans more than 27 years. Early in his professional life, he headed an international NGO in his home country, Mali, and, from 1987 to 2001, represented UNICEF in several African countries. In the area of HIV/AIDS, his most important achievements on the ground include the initiation of one of Africa's first programs to prevent mother-to-child transmission of HIV and the negotiation of the first substantial price reductions of antiretroviral drugs for use in Africa.

Mr. Sidibe joined UNAIDS in 2001, where he has led the movement for Universal Access to HIV prevention, treatment, and care; decentralized UNAIDS operations in over 100 countries; and played a pivotal role in strengthening UNAIDS' collaboration with key stakeholders, including people living with HIV, civil society groups, donors and foundations. He has also led the effort to improve the division of labor among multilateral agencies involved in the AIDS response, and was instrumental in developing and implementing the "Three Ones" principles to better coordinate national AIDS responses.

Mr. Sidibe holds advanced academic degrees in economics, international development and social planning. In recognition of his achievements in the field of AIDS, he was recently awarded an honorary professorship at South Africa's Stellenbosch University.

## **Børre Sør Dahl – Norway**

THINK mental Fashion

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Børre Sør Dahl is co-founder and director of THINK Mental Fashion, a non-profit organization situated in Tromsø, Arctic Norway. His background is from communication, business development, marketing and project management. THINK Mental Fashion was founded in 2007 to infect young people with enthusiasm to fight AIDS through innovative communication concepts. Børre started working with HIV/AIDS in 2004 prior to Nelson Mandela's visit to Tromsø, the world's only appointed 46664 Mandela ambassador city.

## **Hellen Tombo- Kenya**

Plan International- Africa

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Hellen Tombo is the Regional Advocacy Advisor at Plan International. She has an education background of Community Development & Communication, with a training background in facilitation of structuring successful Associations and processes, Equal Status of women, Human Rights, local capacity for peace, , youth leadership/work, civic education and community empowerment to name a few. Prior to joining Plan international, Hellen was the Executive Director of Kenya Youth Education and Community Development Programme.

She has experience of working with youth, children and women and has received various local and regional Awards in community development at various levels. To name a few, she received the East African Community Service Award 2005/6; Daystar University Alumni Award 2008. Hellen has been very core player in the Global Call to Action Against Poverty and Chaired the Global Children and Youth Task Force. Various media publications have been done on her role in advocating for the Children, youth and women issues at various national, regional and global levels. Hellen is actively involved in various civil society initiatives, organizational activities and rights based movement at national, regional and international levels.

In February 2007, Hellen was appointed by the President of Kenya as the Chairman of Board of Directors of the National Youth Enterprise Development Fund, which will definitely input into the development process of Youth Empowerment and engagement in the national decisions. The same year, Hellen was also appointed as the Vice Chair of the biggest Maternity Hospital in the Sub-Saharan Africa – Pumwani hospital. Two years ago, Hellen was also appointed as Poverty Eradication Commissioner in Kenya.

Hellen is a patron of various youth and community groups, board member of development agencies, and has been a key speaker in various forums and conferences and facilitator of various meetings and processes.

**Marte Wensaas- Norway**

Ministry of Foreign Affairs

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Marte Wensaas has been working with in the HIV/AIDS section in the Norwegian Ministry of Foreign Affairs since 2007. Earlier she has been working as an AIDS coordinator for Norwegian Church Aid in Malawi and as a social worker in Kenya. In the Ministry she is the contact person for aids2031 projects.

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## Annex 2. Summary of Constituency Feedback

### Introduction

Based on a desire to garner new thinking in the response to the HIV epidemic, in October 2008, the aids2031 Programmatic Response Working Group approached leaders of a range of constituent groups<sup>2</sup> outside the United Nations system to seek their views on the following three questions.

- *What has been successful in the current response to the HIV/AIDS epidemic and what do you think is critical to keep for a good response in the long-term?*
- *What are the new ways of thinking required to effectively address the challenges you are facing in achieving universal access to prevention, treatment, care and support? How would you address these challenges?*
- *What kind of leadership is required to shape and guide this “new” response and how can you (the group that you are part of) contribute?*

The majority of constituencies responded to the call and collected the feedback that is highlighted in this summary. These responses were gathered from 10 different groups (children, child soldiers, commercial sex workers, faith-based organizations (FBOs), intravenous drug users (IDUs), men having sex with men (MSM), nurses, parliamentarians, people living with HIV (PLHIV), prisoners, women, youth and young PLHIV) spanning all continents and regions, but with a greater representation from African and Asian countries.

It is important to note that some of the views expressed in this summary are those of individual members of various constituencies, not necessarily the constituency as a whole. In addition, the summary is not representative of the state of the epidemic in all groups and regions. Instead, it aims to capture the trend of thinking and new ideas that need to be pushed further in the long-term in response to the HIV epidemic. It also serves as a starting point for further discussion, which begins at a November 20-21, 2008, constituency consultation in Oslo. The focus there is on identifying the most innovative thinking with respect to recommendations for the way forward and, how communities can be involved in implementing these recommendations.

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<sup>2</sup> The constituency groups include: armed forces, children, child soldiers, commercial sex workers, faith-based organizations, health workers, intravenous drug users, men who have sex with men, migrants, parliamentarians, people living with HIV, prisoners, women and young people.

## **Main successes, challenges, recommendations**

Reviewing the responses, it is clear that progress has been made. The main successes reported by the constituencies include strong commitment at the global level, a significant increase in available funds, and greater involvement of PLHIV and other target groups. Access to treatment has increased, and many of the AIDS campaigns have contributed to more awareness in the general public.

Still, the list of challenges seems longer than the one for successes. Stigma remains a barrier, and access to comprehensive sex education is not yet adequate. While available treatment is available, care is still insufficient and even condoms are not being used, despite the increased awareness. Much of the progress has not yet reached many of the rural areas, and groups at risk are lacking the more specialised interventions required to meet their needs.

Interestingly, the list of suggestions on the way forward is by far the longest of the three. Here, the constituencies want to more directly address the social drivers of the epidemic, coming to grips with stigma and discrimination, and linking HIV/AIDS with gender and human rights. They also point to the importance of involving all groups when fighting HIV/AIDS—strengthening the voices of all those concerned.

Many of the constituencies share the same perceptions when it comes to successes, challenges and the way forward. At the same time, they bring their own perspectives and experiences, which—to a large extent—is specific to their own constituency. And, there are some issues that are not raised, such as the role of PEPFAR (the U.S. President's Emergency Plan For AIDS Relief) and other donors, how increased funds have actually been used, and whether they have been spent efficiently or not.

As such, the responses summarized here provoke a number of follow-up questions, some of which have been touched upon, but will be further explored during the November Oslo meeting. These include:

### **Successes**

Putting HIV on the global agenda

*Has increased funding trickled down to the NGOs and civil society organisations leading the response at the community-level? Have these global commitments recognising the specificities of the epidemic really led to implemented changes at the community level?*

Greater awareness

*In many countries, we have awareness of AIDS but not behaviour change – how do we move from awareness to action? Why is being aware not enough to change behaviour? Is there a way to make mass media campaigns that raise awareness also more likely to cause behaviour change?*

Greater involvement of civil society

*How do all the "international" AIDS bodies – Global Fund, UNAIDS, etc. – function at the country level? What could they be doing better to involve civil society? Are they relevant to your work?*

## Challenges

### Stigma and discrimination

*All the groups identified stigma and discrimination as key factors to address. How? Why are the current programs not working, and what can we address to ensure anti-stigma and discrimination programs have impact? How can we create long-term change around stigma and discrimination?*

### Absence of comprehensive sex education

*How can we better advocate for and integrate comprehensive sex education, in a way that respects socio-cultural norms?*

### Preventing new infections

*A major prevention strategy is still the male condom. Is this working – why or why not? How can we better 'sell' condoms – can we make them exciting? How can we create a global demand for condoms? On the female condom – where has this been successful? Should we continue advocating for its use?*

### Gender imbalance

*We know everyone has a hard time talking openly and gender, sex, and sexuality. How can we start changing this in countries so that we can break barriers? How can we initiate dialogues around being gay, transgender – how can we move gender from strictly being 'man' versus 'woman'?*

### Service delivery

*The response to HIV/AIDS has been seen as “exceptional”—that is, separated from other health issues, as evidenced by, for example, the creation of UNAIDS and the establishment of separate national AIDS programmes. Should this continue to be the case or not?*

### Treatment without care

*There is a definite need to treat HIV-positive patients holistically and improve the relationship between them and health-care providers. Which strategies can help to achieve this? Greater access to services is needed but how can we reach people in more remote areas? How can we ensure that when services exist, they are of good quality?*

### Public Policies

*Where is the "youth movement" stuck? The movement has been making this same point for a long time – how should its tactics change? On peer education on sexual health – there is no evidence yet to support this. How can we support more research into youth prevention and generate evidence for what works?*

*How does criminalising HIV transmission impact on HIV incidence? How is criminalization of homosexuality and sex work hamper effectiveness of the future AIDS response?*

### Weak monitoring and evaluation

*How can we ensure the design of evidence-based programmes, based on reliable epidemiological and population data?*

## The Way Forward

### Social Drivers

*How can we counter the socio-economic implications of the HIV epidemic at the community level, in particular those that could reinforce the drivers of the epidemic? Which community leaders are serving as moral gate keepers? Should religious leaders take on a greater role at the community-level?*

*How can the public health sector and the human rights sector better integrate their efforts?*

### Prevention

*How can we reinvigorate the prevention movement while simultaneously pushing for universal access to treatment? Who can be leaders on prevention?*

*How can communities play a bigger role in designing and implementing comprehensive and inclusive prevention interventions? Are donors supporting the right prevention interventions on the ground? Are they supporting prevention interventions most needed in countries or not?*

*In Southern Africa, how are communities addressing multiple concurrent sexual relationships? Do you think international partners are/are not addressing this?*

### Treatment

*What is a strategy for better linking of sexual and reproductive health and HIV services? Why did we abandon these linkages – was it politics? Morals? How can we get back on track?*

*How can we ensure that health services do address the concerns of those in need of HIV prevention, treatment, care and support*

### Public Policies

*How can we ensure health systems prepare for and offer high quality sexual and reproductive health services for young people living with HIV and for women?*

*Many countries do not have data disaggregated by age, sex, and sexuality, making it difficult to design effective prevention programmes. What can be done to improve data collection?*

### Thinking “outside the box”

*What might be some innovative—perhaps even contradictory—approaches to conventional programming?*

*What is meant by a multi-sectoral response? Moving beyond “typical” sectors? Who is not involved in AIDS that could help get us where we need to go? Who’s gotten involved in AIDS in a harmful way?*

*We all talk about the “AIDS industry.” How do we get rid of people profiting on AIDS? Are there too many NGOs; too many international employees, too many conferences?*

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## Successes

*What has been successful in the current response to the HIV/AIDS epidemic and what do you think is critical to keep for a good response in the long term?*

### **Putting HIV on the global agenda**

The past years have seen greater global commitment and funding through the creation of innovative mechanisms to respond to HIV at various levels (for example, the Global Fund to Fight AIDS, Tuberculosis and Malaria, UNAIDS, collaborative funds, community-based organizations (CBOs), etc.) (PLHIV constituency). Many groups viewed the Global Fund as being successful in bringing partners together and increasing the levels of funds available at country-level, driven by country needs. Similarly, FBOs and other groups noted that UNAIDS' efforts have been successful in bringing key stakeholders together and mobilising global political and financial commitment. UNAIDS was able to provide guidelines and leadership for a more coordinated response (prisoners constituency).

Global commitments, such as those formulated at the G8 meeting, were successful in acknowledging the feminisation of the epidemic in certain parts of the world (such as sub-Saharan Africa) and the lack of sexual reproductive health rights, and in recognising the rights of sexual minorities (women constituency). Global campaigns have also contributed to greater focus on gender issues. The women identified the decisions by the UNAIDS Board and the Global Fund as a means of encouraging and supporting countries to invest in activities to reduce gender inequalities.

### **Greater awareness**

The creation of UNAIDS and the Millennium Development Goals campaign were successful in increasing awareness and funding for the response to the epidemic. With this global mobilisation has come greater awareness among the general population and most-at-risk groups. As one of the members of the MSM community stated, people's awareness of modes of transmission and ways of prevention have greatly improved since the onset of the epidemic.

Many groups mentioned the importance of the media in conveying messages to dispel the myths around the disease (prisoners constituency). Mass awareness campaigns for HIV through billboards, posters, leaflets have been improved (children constituency). The young people constituency mentioned the importance of radio programmes and youth-led events around key dates (World AIDS Day, Global Week of Action) to mobilise the youth.

At the community level (in churches, markets and stadiums) awareness campaigns are also expanding (child soldiers constituency), and culturally sensitive methods used in sketches, theatres and postcards had been effective in informing people. Others claimed that site trainings have proved to be much more effective than wide-scale awareness campaigns or distribution of printed materials (young people constituency).

### **Expanding access to ART**

Nearly all consistencies identified increased access to antiretroviral treatment (ART) in low- and middle-income countries as a major success. Access to ART has meant access to life for millions of people. The nurses constituency welcomed the 3 by 5 initiative (3 million people on ART by 2005), saying that it was a best-practice model of treatment scale-up. The FBO constituency mentioned pressure by governments and donors on the pharmaceutical industry to lower prices and to not enforce patents, as well as the introduction of generic medicines as a contributing factor to the scaling up of ART. Target-setting for enrolment of clients in ART programmes has also been a successful strategy: adherence to treatment has improved, as has the quality of life of many PLHIV (IDUs constituency).

### **Expanded HIV services**

Several consistencies identified the scaling up of prevention of peri-natal transmission of HIV as a success. The nurses constituency praised the integration of compulsory prevention of peri-natal transmission activities into antenatal packages. Other positive aspects include more screening and identification of HIV-positive people, more testing and treatment of sexually transmitted infections (STI) and increasing confidentiality (nurses constituency). The women constituency pointed out, however, that testing should not be mandatory and is only useful if coupled with comprehensive treatment, care and support.

The nurses constituency highlighted linking nutritional support organisations, such as the World Food Program, with ART centres as a successful strategy to support clients on medication. The MSM constituency also recognised the importance of nutrition and medical support for HIV-positive MSM.

For IDUs in the Ukraine, the main success in terms of providing services was the introduction of substitution therapy, both as a way of preventing the spread of HIV among IDUs, but also of increasing adherence to treatment.

Successful examples of service delivery include the establishment of additional youth-friendly resource centres (children constituency), as well as drop-in centres for MSM recreation and peer-to-peer information sharing for safer sex (MSM constituency). Increased access to MSM-friendly STI/HIV/AIDS prevention, care and treatment services have led to greater use of these services (MSM constituency).

The sex workers constituency praised the move from disease-control to comprehensive care (including human rights, confidentiality, and integrated free testing services). The integration of HIV testing and counselling services in tuberculosis settings, the management of co-infection, and the decentralisation of HIV/AIDS services to reach even the rural communities were also mentioned as successes (nurses constituency).

## **Involvement of target groups**

### *At the global decision-making level*

All constituencies highlighted that one of the main successes in the HIV response has been the involvement of PLHIV, youth, and other key populations in policy development and decision-making. The IDUs constituency noted the greater participation of PLHIV and IDU representatives in decision-making in all governmental bodies responsible for the response in the Ukraine, especially during government tender meetings.

There has been greater involvement of many players in the AIDS response (state, NGOs and churches, traditional leaders, etc). There has been a strengthened participation of civil society in decision- and in policy-making processes, such as UNAIDS' Programme Coordinating Board, the Global Fund and UN High Level Meetings (UNGASS) at the global level, and Country Coordinating Mechanisms at the national level. There has also been greater participation of FBOs in providing services in response to HIV.

### *In programme implementation*

There has been more emphasis in mobilising communities, especially people most-at-risk, to develop their own responses. Implementers are increasingly part of the targeted communities themselves (MSM constituency). For example, greater involvement of PLHIV as expert clients in programmes like ART literacy to help other clients understand, and cope with, treatment was mentioned by the nurses constituency as having been successful. While HIV-positive women are being increasingly involved, there is still a need to engage them much more substantially so that they are given a voice that is respected in decision-making, planning, and implementation (women constituency).

Sex workers mentioned that engaging them as entry points to prevention had been a successful strategy to reach out to their clients, and the expertise of young sex workers has been increasingly recognised in prevention work.

Building networks and support groups for MSM to assess their STI and HIV risk behaviors and adopt safer sexual behaviours were also mentioned as an effective strategy.

## **Greater involvement of civil society**

The constituencies reported seeing greater participation of civil society and communities as one of the successes. As mentioned by the young PLHIV, there is growing acknowledgement within the international community of the important role of civil society in having a far-reaching impact. There was also greater participation of FBOs in providing services in response to HIV. In particular, the greater involvement of communities and PLHIV in responses was mentioned as a success: there have been successful strategies shaped around community empowerment, peer-to-peer education, as well as the provision of services by community members themselves. The youth group stressed the success of having communities participate in the response and not merely being recipients of information and services. The MSM community highlighted the importance of working directly with community leaders and individuals personally to involve them in all levels of intervention, from programme design to programme evaluation.

Groups also reported increased levels of volunteerism to respond to the epidemic, like the role of grandmothers caring for orphans. The prisoners' constituency also mentioned the increased assistance provided to the growing orphan crisis, particularly in Africa.

The majority of the constituencies highlighted successful public education schemes, particularly relying on peer education. Children mentioned more sexual and reproductive health education, more information provided for women (treatment literacy around sexual and reproductive health and rights) and more integrated HIV activities in school and universities.

Several consistencies highlighted the increase in training and counselling. The child soldiers constituency valued HIV training about modes of transmission in the military, which include young child soldiers under their command. The MSM mentioned greater training and income-generating activities for their peers. Greater investment in human capacity building and development, more training at the grassroots level, as well as more informal teaching were highlighted by several groups as very successful strategies. The nurses constituency highlighted providing health workers with training to perform HIV testing and providing ART, including prevention of mother-to-child transmission therapy as successful strategies.

## Challenges

*What are the new ways of thinking required to effectively address the challenges you are facing in achieving universal access to prevention, treatment, care and support? How would you address these challenges?*

### **Stigma and discrimination**

The majority of the constituencies identified stigma and discrimination as one of the main challenges in the AIDS response. PLHIV cannot break the silence of their status due to fear of stigma and discrimination from other community members, families and healthcare staff (child soldier constituency).

Social stigma is a major barrier to accessing services and information, but it also inhibits treatment adherence (young PLHIV constituency). It is a barrier to accessing services and information, and impedes the provision of advocacy support for MSM CBOs and organisations working with MSM to outreach their visible and hidden peers.

There is also a double burden of stigma for most-at-risk groups like sex workers, IDUs and MSM living with HIV. It is more difficult to access health services and treatment for HIV and STIs for PLHIV and, in particular, the most marginalised groups, like sex workers. Sex workers who are HIV-positive do not, for instance, identify themselves as sex workers when they access treatment and care, to avoid double stigma. The lack of confidentiality in health services is also leading to greater discrimination.

The young PLHIV and the IDUs mentioned that the specific needs and problems of young HIV-positive people (such as reproductive rights, sexual life, disclosure of their status, etc.) are not widely discussed with friends or teachers, meaning that they are inhibited from becoming full members of their communities, for example, their universities.

### **Absence of programmes addressing sexual and reproductive health**

Several constituencies highlighted the lack of access to sex education. They claimed that specific action is needed to promote sexual and reproductive health among adolescents and to address the sexual and reproductive needs of adolescents living with HIV. Along those lines, the PLHIV group highlighted the fact that HIV-related and sexual and reproductive-related programmes and services must be more closely linked and integrated. The MSM constituency identified the lack of appropriate education tools to reach hidden MSM as a major challenge. The women constituency also highlighted the lack of appropriate access to sexual and reproductive health services that work for women, including HIV-positive and young women.

There are taboos around sex and great social taboos, superstitions, fears and ignorance surrounding HIV/AIDS. There is no dialogue around sex, as mentioned by the young people constituency, and there is limited openness and frankness to address all issues related to HIV/AIDS, including the sensitive issues of sexuality and sexual relations. Adults usually do not want to listen to children, so young and adolescent groups should be given the opportunity to work with adult people of their community (children constituency). Taboos around sexuality are a major barrier to successful prevention work.

### **Preventing new infections**

Preventing new infections was highlighted as one of the major challenges by most constituencies. There is a lack of locally designed, adequately supported and targeted behavioural prevention strategies (FBO constituency). It is critical that each country and each community understand the epidemiology of their own epidemic and then design locally appropriate interventions, which should include much more than promoting the use of condoms. The MSM constituency raised the issue that there are no appropriate interventions for the very different sub-groups within MSM. Interventions for transgender people, for example, will not be appropriate for gay men.

There is limited availability, accessibility and affordability of female-controlled prevention technologies such as female condoms (women constituency), and there is misuse of condoms by children (child soldier constituency). Condom and lubricant supply is not being addressed systematically, there is no comprehensive planning for ensuring adequate supply to countries, and there is very little discussion of quality control (MSM constituency). Circumcision is not featured in public education campaigns (sex workers constituency). There is an unwillingness to involve sex workers in prevention and a lack of youth leadership in prevention programmes.

### ***Condom use***

The use of condoms remains one of the principal modes of preventions but men avoid using them, even when they are available (sex workers constituency). Women (and sex workers) in different parts of the world are not equipped with the skills and confidence to negotiate condom use with their partners or clients. In addition, condom programmes and campaigns have systematically focused on women rather than men, and it is felt that women have been given the responsibility for protecting everyone with no support.

### ***Gender imbalance***

Many constituencies highlight gender imbalances as one of the main challenges of the AIDS response, in both generalized and concentrated epidemics. The main thinking across groups was that gender inequalities in sexual reproductive health and little male involvement in sexual reproductive issues are a major challenge in preventing new infections. Programmes and interventions are not gender-sensitive. There is a lack of holistic approaches to gender-responsive programmes and policies that involve men and women, as well as sexual minorities in changing traditional gender imbalances and roles (PLHIV constituency).

The sex workers group highlighted the fact that HIV campaigns are only directed towards women and not towards men, and that policies are failing to address gender imbalances, violence, dependency and cultural/social factors. For instance, there are no public education campaigns promoting circumcision, and free circumcision clinics are yet to be advertised.

Also, the FBO constituency points out the importance of gender issues; it should be accepted that women have responsibilities and power over their bodies, while the prisoners constituency state that HIV/AIDS represents a crisis of women's rights.

## **Service delivery**

### ***Treatment without care***

The sex workers constituency noted that a holistic view around treatment is lacking, and that the provision of ART is merely one aspect of the treatment package needed for people living with the disease. HIV is not well enough integrated into STI and sexual reproductive health services; there is the increasing problem of resistance and lack of follow-up of patients on treatment as well as provision of nutritional support to PLHIV. Several groups including sex workers mentioned the lack of psycho-social care and support and follow-up of patients and families.

Many constituencies reported the absence of confidentiality when going to health clinics and the absence of quality interactions between patients and health providers. Fear of disclosure and breaking of confidentiality was raised as a major challenge for PLHIV.

Constituencies also mentioned the high price of drugs and the difficulty to access those by the most at risk groups. The FBO group raised the alarm about the increasing drug resistance and the high price of second line ARVs that will become a real challenge to continue treating those on already on treatment in the near future.

### ***Access, availability and quality of services***

Several constituencies mentioned the difficulty in reaching people in rural areas, and problems related to the lack of decentralized of services (nurses constituency). The FBO constituency noted that task-shifting should be taken forward if treatment services are to reach rural areas to much larger degree. To this end, there is a need to strengthen collaboration between community-based service providers (FBOs, positive networks, local governments, etc.) and technical service providers (UNAIDS, WHO, CDC, etc.).

Some constituencies highlighted the absence of VCT services and clinics, and the inequities in access to treatment for women and key populations (PLHIV constituency).

The MSM constituency pointed to the lack of specialised clinics for youth/MSM etc. There is also a lack of youth-friendly facilities (clinics/health professionals/counsellors) (young people constituency)., The MSM constituency also mentioned the lack of learning centre for MSM, the lack of VCT services and the knowledge that services exist, and the lack of training and formation of health personal.

The FBO constituency highlighted brain-draining of skilled health care workers in developing countries as a major challenge, while the MSM constituency noted a lack of staff/personnel with skills to implement MSM projects/activities.

## **Public policies**

### ***Lack of specialised interventions***

The lack of specialized and tailored interventions was mentioned as one of the key challenges by most consistencies. There is a need for more consultations among key populations, including PLHIV and a need to create a special package of interventions for vulnerable groups such as commercial sex workers, MSM, IDUs, uniformed servicemen,

refugees, OVCs, PWDs (parliamentarians constituency). There is a need for focused and evidence based on HIV/AIDS prevention programmes to effectively address the changing National HIV/AIDS transition dynamics (parliamentarians constituency).

### ***Youth not consulted when shaping prevention strategies***

The youth is not being included in the decision-making process and politicians do not take the youth and their experiences, realities, ideas and sexualities seriously (young people constituency), even when they are the best placed to inform on prevention strategies targeting the youth. Abstinence-only values and anti-abortion policies are promoted without respecting the choice and realities of young people (young people constituency).

### ***Integrated, multi-sectoral, multidimensional approach to programming***

There is a lack of mainstreaming of HIV/AIDS in the public sector, and a lack of an integrated, multisectoral, multidimensional approach to programming (FBO constituency). The socio-political and economic dimensions of the HIV epidemic are not addressed. There is a lack of evidence-based advocacy tools, there is hesitance to cooperate by certain groups/authorities and in some countries, national AIDS control programme lacks political commitment.

### ***Criminalisation of most at risk groups and legal issues***

Criminalisation was highlighted as an important challenge by many of the constituencies. Sex workers pointed out that there is no distinction made by the government between trafficking and the profession of sex workers. And that eliminating the criminalisation of sex work must be a part of any HIV policy or program. There is an overall lack of recognition by political leaders of the problem of HIV/AIDS among sex workers and weak legal assistance systems for sex workers.

Criminalisation of homosexuality in many countries is hampering access to healthcare and prevention strategies and drug-use laws are preventing harm-reduction programmes from working (young people constituency). For instance, in India, as mentioned by the youth group, no agreement has been reached among ministries over the introduction of sex education in schools and over the issue of criminalization of same sex behaviour. The criminalisation of HIV transmission is being adopted by countries under the garb of addressing violence against women and “protecting” women and girls from transmission. The reality is that these policies are not based in human rights and increase women’s risk to violence, disinheritance, dispossession and even HIV transmission (women constituency). PLHIV mentioned that evidence must be gathered on the impact of the laws on responses to HIV.

### ***Weak monitoring and evaluation***

Several constituencies mentioned the absence of evidence-based HIV/AIDS prevention programmes to effectively address the changing National HIV/AIDS transition dynamics. The FBOs mentioned the lack of continuous documentation of successful programmes (FBOs). There is a need for focused and evidence based on HIV/AIDS prevention programmes targeting vulnerable and most risk populations to effectively address HIV/AIDS.

The MSM constituency reported that the lack of strategic information (for example, population size, coverage of interventions, etc.) hinders the advocacy support and the design of appropriate interventions. They also reported that lubricant supply is not being addressed systematically. PLHIV also mentioned the lack of evidence-based advocacy tools (PLHIV). Evidence of the impact of PLHIV networks through the development of indicators that are appropriate to PLHIV networks' programmes will support such advocacy. The youth also mentioned the gap and lack of linkages between the youth and researchers and the lack of advocacy with evidence based data

As mentioned by the youth group, HIV/AIDS is not only affecting people in the developing world, there are also rising levels of infection in Western and Eastern Europe that must be monitored.

## The Way Forward

*What kind of leadership is required to shape and guide this new response and how can you (the group that you are part of) contribute?*

### SOCIAL DRIVERS

#### **Tackling the root of stigma and discrimination**

All consistencies recognised the importance of reducing stigma and discrimination. There is a need to reduced stigma in order for people to access help and the acceptance of help as a possibility to deal with HIV before it is too late

The FBO constituency points out that it will be critical to come to a growing understanding of socio- cultural implications when we talk about sexuality, disease, morality, stigma, etc. In our western societies, it will be critical to overcome the impression, that AIDS is something that is only affecting people in the south and not us and our churches.

The young people constituency calls for tackling the root of stigma/discrimination by expanding dialogue on sexuality, substance use, safe sexual behaviour, sex work, concepts of choice, sexual and reproductive health, living with HIV.

The sex workers constituency call for the recognition of the sex workers reality and work, and suggest that this can help fight stigma.

The nurses constituency mentioned community based dialogues to reduce stigma and discrimination of HIV infected persons. And, the parliamentarians constituency called for leadership that promotes and advocates for gender equity and equality and abhors discrimination to access on grounds of sex, colour, ethnicity, religious beliefs and all other forms of discrimination.

The prisoners constituency suggested leadership that ensure the accelerated implementation of national strategies for women's empowerment, employment, protection of human rights and elimination of all forms of discrimination

#### **Linking gender and human rights**

Several consistencies highlight the importance of addressing gender issues in the future AIDS response. The nurses constituency highlight the need for programmes addressing gender inequalities in sexual reproductive health where males are decision makers and dominating.

The prisoners constituency point out the need to make connections between women's rights and human rights. By understanding that women's rights are explicitly human rights, will help explore how human rights violations are directly contributing to the escalation of the HIV/AIDS pandemic and the cyclical nature of this relationship. HIV/AIDS represents a crisis of women's rights (prisoners constituency). The prisoners constituency also calls for governments to live up to its promises made through various international agreements- such as The Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) and International Conference on Population and Development (ICPD).

The women constituency highlights that the leadership must unequivocally be committed to human rights-based and gender sensitive response. It needs to develop and execute a rights-based gender sensitive response to AIDS in all regions (with generalised and concentrated epidemics); and in regions where women and girls are more affected than men and boys, gender equality and women's rights should be the core business of the response.

Others raised the fact that HIV policies have been up to now insensitive to social and cultural differences and that we must not expect traditional gender imbalances to change from one day to the next. As such, the HIV response should take into account cultural differences, sexual behaviours and power structures between men and women, as well as the strong influence of religion in people's lives, and adapt policies to different socio-cultural contexts (sex workers constituency).

Sex workers mentioned that women should be taught and trained to better negotiate condom use with their partners, taking into account sexual behaviours and gender imbalances specifically tailored to each country. Women should have the right to have responsibilities and power over their own bodies (FBO constituency).

## **PREVENTION**

### **Involving men in the response**

All programmes need to be aimed clearly at men to promote condom use. It must not be hidden behind gender values, or dressed up as family values. The sex workers constituencies suggested that men should use condoms and as well consider the benefits of circumcision. Promotion of male prevention must be led by men, especially those working in the AIDS industry: policy makers, HIV-positive, scientists, programmers, activists, sex workers, youth, soldiers, and police. They suggest to perhaps begin with an International Conference on HIV/AIDS for Men, where men talk to men, discuss men's use of condoms, men's power, men's sexual identity to come up with how men going to deal with men's issues as a gender—should be part of gender agenda.

### **More HIV education and peer-to-peer training**

Several constituencies highlighted education and training as essential for the future AIDS response. The youth raised that it was critical to integrate HIV/AIDS into the national education programme in the form of sex education at the primary and secondary level.

There is a need for more learning centres, and treatment literacy should be incorporated into most prevention programmes (PLHIV constituency). There should be promotion of "comprehensive Prevention" and treatment literacy should be incorporated into most prevention programmes.

Health, especially reproductive health, should become more visible part of the HIV programmes of faith communities.

There is a need to promote and increase access to health information, products and services among MSM.

There is a need to expand capacity building services by increasing the outreach of free online courses as well as connecting young people to grassroots trainings and other youth-friendly resources.

### **Which prevention interventions for the future?**

Make greater investments in prevention, particularly for girls and women. In particular, significant investment should be made to introduce and provide female condoms, ensure access to reproductive health services, and identify effective structural interventions that render women less vulnerable, including comprehensive, rights-based sex education and zero tolerance for sexual violence (women constituency). Female condoms play an important role in prevention – important constraints to their use are availability and price (FBO constituency). Successful strategies could include routine testing (FBO constituency) and strengthening and decentralising male circumcision (nurses constituency). PMTCT services must continue expanding in low and middle-income settings (PLHIV constituency).

There is a need to involve PLHIV in the in new prevention technologies. This includes participation in the development of trial protocols and ensuring that new prevention technologies are appropriate and reflect the needs of PLHIV (for example, ARV-based microbicides) (PLHIV constituency).

The youth perspective is crucial for prevention programmes. As such, youth in general and youth in faith/religious settings in particular should be more involved and more heard (FBO constituency).

There is a need to ensure appropriate interventions for the very different sub-groups within the MSM community. Interventions for transgender groups, for example, will not be appropriate for gay men, etc (MSM constituency).

Reaching rural areas with prevention messages was mentioned by some constituencies as being of particular importance in the future AIDS response. The children constituency advocated that emphasis should be given on displaying pictorial messages over written messages in rural areas. These messages will be simple so that more people will be able to understand messages. They also suggested that billboards, posters, banners may be displayed on large trees or market premises where rural people gather everyday.

## **TREATMENT**

### ***Integrating HIV into sexual reproductive health programmes***

Several constituencies raised the need for a paradigm shift, where sexual and reproductive health and rights services and HIV/AIDS programmes are mainstreamed into regular healthcare and prevention policies. PLHIV supported this and stressed that HIV and sexual and reproductive-related programmes and services must be more closely linked and integrated. The FBO constituency underscored the importance of greater integration of HIV and tuberculosis treatment programmes, particularly in Southern Africa, and the need for greater literacy on tuberculosis treatment.

### ***Rethinking the treatment/care/support system***

There needs to be expanded access to testing and post-diagnosis follow-up in low and middle-income countries. To ensure access to treatment continues to increase, attention must be given to second line ART, sustainability of treatment efforts, bridging the gaps in inequities, and increase access to treatment services beyond only ART (for example, viral load, CD4 counts, etc.) (PLHIV constituency).

The FBO constituency pointed out that there is a need to re-examine the current care and support system to meet the modern trends. Before books and manuals are written on care and support, surveys should be conducted and recommendations put in place.

Quality of treatment must be standardised as we move away from emergency-service delivery to a systematic service-delivery of treatment and quality of care (PLHIV constituency). There is a need for better referral systems (MSM constituency).

Health services should be more user-friendly and attractive to hidden populations such as MSM. And more MSM clinics should provide comprehensive services (MSM constituency). Voluntary counselling and testing centres should ensure that their opening times are convenient for men; clinics should advertise that they provide services for men (not just women) and consider employing some male staff (very few men feel comfortable talking to female nurses about sexually transmitted infections and other sensitive issues) (FBO constituency).

The FBO constituency also suggests that 100 families should have one doctor/nurse in resource poor countries such that the doctor can visit at least one family per month. This would provide an opportunity for each person or family to know their status and effectively followed up for other diseases. This will not only address HIV/AIDS issues, but also help strengthen the health system.

Closer collaboration between official medical services and traditional healers is necessary if treatment is to be successful (FBO constituency). Currently, many people do not disclose to a doctor that they are also taking traditional medicines, which could increase the risk that their ART becomes unsuccessful as drug interaction occurs. At the same time, many traditional healers are not well-versed on HIV and AIDS.

## **PUBLIC POLICIES**

### ***Stronger partnerships and consultations of PLHIV***

Several constituencies mentioned different ways of achieving Universal Access to treatment, care and support. There is a need to reaffirm and recommit to the concept of Universal Access (FBO constituency).

National responses to HIV and AIDS should be multicultural and involve growing and strong partnerships between the government and key government ministries, civil society and the private sector, and they especially need to include more players in the marginalised population (MSM constituency). More attention needs to be placed on ensuring inclusiveness of civil society to ensure that needs of key populations are addressed. There is a need to strengthen consultations among key populations, including PLHIV (PLHIV constituency).

Young PLHIV believe we need to expand know what works and stop what we know does not. We need to shift from unhelpful vertical- versus horizontal approaches to Positive Synergies, connecting the various initiatives: Universal Access, IHP+, UNITAID, the GFATM, etc.).

### ***Addressing the needs of PLHIV***

Rights-based policies must be improved and there is a need for increased support to work that directly benefits key populations, such as MSM, sex workers, people who use drugs etc. (PLHIV constituency).

It was raised by several constituencies that there is need for initiatives to proactively identify factors that increase vulnerability and susceptibility of communities to AIDS and address them. The youth mentioned the importance of developing a more holistic view of the epidemic noting how race, class, geographic location, gender, sexuality, age, etc. contribute to people's vulnerabilities.

### ***Sustained funding and capacity development***

As mentioned by the IDU group (Ukraine) the main challenge for the future in achieving universal access will be sustaining the HIV response after GFATM funding will be finished with the grants.

The need for more capacity development was highlighted by the MSM and the PLHIV consistencies. They called for strengthen capacity of CSOs, including PLHIV networks, through core funding support. The majority of funding continues to be on a project-based approach. However, for a strengthened participation of civil society in policy-making processes, attention must be placed on core business of these organisations.

The MSM community stressed the need to train core community volunteers and to promote community services that could generate greater impact within the community.

Staff turnover is high in many CSOs, and incentives for project staff as a means to promote morale/retention of staff is important. There is a need to strengthen CBOs, to build the capacity of implementing agency staff, partners and stakeholders to plan, implement, manage and monitor the program.

### ***Empowering women***

The sex workers constituency called for the elimination of stigma and criminalisation of sex work. The women constituency asked for adequate financing for women's empowerment programmes that would provide women with opportunities for decision-making. Such programmes would include training, followed by support and skills-building for community mobilization. The issues of women's empowerment and gender equality are often appendages to the AIDS response instead of being an integral, cross-cutting component of all programmatic and policy issues. Many existing national prevention, treatment and care strategies do not contribute to an environment supportive of gender equality, as they are not developed within the context of women's realities.

### ***Monitoring and evaluation***

There is a call for more evidence informed programming: This would help programmes to deal with critical and empirically founded to inform programming (FBO constituency). Evidence-based advocacy must become a priority, going beyond anecdotal evidence (PLHIV constituency).

There needs to be a paradigm shift to a results-based management culture, there is a greater need to measure both outputs and outcomes and their effect on the final impacts of programme and project activities (prisoners' constituency).

### ***Thinking outside the box***

We need to think beyond conventional thinking and look for crosscutting issues, such as: how does stigma inhibit treatment adherence, how does criminalizing HIV transmission impact on HIV incidence, how can reduced viral load impact and reduced infectiousness be used in effective prevention approaches, etc.

Many consistencies highlighted the need for better and stronger public policies. The children constituency suggested that governments can make mandatory for the producers to print HIV warning messages in the packets of essential household items, for example, packets of salt, flour, rice, oil etc. like cigarette packets.

### ***A new kind of leadership for the response***

All consistencies had an opinion on what kind of leadership the AIDS response needs. Many called for strong leadership at all levels of society and should include the full and active participation of civil society and the private sector (prisoners' constituency). The FBO constituency pointed out the need for coordinated, constant supportive leadership, from the highest levels of government, civil society, and church. Too often we only have support from these highest levels on World AIDS Day. This support must be consistent (FBO constituency).

There is a need for leadership that will share information with stakeholders and that involves PLHIV and marginalised high-risk groups. Leadership should be put in the hands of sex workers (sex workers constituency). Leadership must be proactive and pragmatic and fully equipped knowledge and information about HIV/AIDS (parliamentarians constituency). The leadership should be involved in resource mobilisation and equitable allocation in order to address critical areas of HIV/AIDS prevention, care, treatment and support (parliamentarians constituency). The leadership must unequivocally be committed to a human rights-based and gender sensitive response (women constituency). Leadership must be accountable (nurses constituency).

The PLHIV constituency pointed out that political leadership must be sustained and expanded not only to maintain HIV on the political agenda, but also to speak out against discriminatory policies and laws regarding sexual and reproductive rights of PLHIV, criminalisation of HIV transmission, stigma and discrimination and gender imbalances that place women at a heightened vulnerability to HIV (PLHIV constituency).

The young PLHIV mentioned that the leadership that is required for the future is one that is not hindered by ideology or moralistic judgement, but one that is based on human rights. Leadership that is willing to translate these rights into tailor-made, specific

interventions for those most in need of support; which means not being afraid to move into unpopular, difficult areas such as drug use, sex work, etc.

### ***How all groups can contribute to the long-term HIV response***

All consistencies highlighted the importance of involvement of different groups in the fight against HIV/AIDS. Greater involvement of PLHIV is needed in all aspects of the national response; policy development, programmed planning and implementation, and service delivery (PLHIV constituency). PLHIV networks must continue working in advocating for the sexual and reproductive rights of PLHIV. PLHIV networks and must ensure that the needs of key populations, and in particular those living with HIV, are included and are voiced in the development and/or adaptation of existing policies (PLHIV constituency). New leadership among the PLHIV movement, including young leaders, must be developed through specific leadership, mentorship and peer-support programmes (PLHIV constituency).

The involvement of women was also highlighted in the responses: There is a need to work to strengthen grassroots movements of HIV-positive women, this will lead to stronger national, regional, and international advocacy by HIV-positive women (women constituency). The prisoners constituency pointed out that leadership of young women will be one in which power is realised within themselves and then developed in others., and as young women leaders it is imperative to “see” this power and to help develop it in others. The women constituency highlighted the need to ensure that the voices and experience of PLHIV—especially women and girls whose voices are too often silenced—are given prominent position in designing and scaling up the global AIDS response.

The involvement of young people was highlighted by many of the consistencies. The FBO constituency pointed out that the participation of young people at every level is critical—programme design, evaluation, analysis, implementation, and policy. The young people constituency highlighted involvement of youth at all stage of programme development (formative research, programme identification, development, implementation and evaluation). They also highlighted the need to strengthen youth leadership and build their skills and capacities. We can stand on behalf of other youth in our societies to speak on the challenges we are facing and what do we need as young people to pass them (children constituency). In schools we can make better active participation of students in the Sexual Reproductive Health Education. We can be leaders promoting changes in sexual behaviour (children constituency). The FBO constituency pointed out that children should also be included in the response and that children often are the missing face in the response to the epidemic. While the children constituency pointed out that adults usually do not want to listen to children and that young and adolescent groups should be given the opportunity to work with adult people of their community.

It was mentioned several times by different constituencies that religious and local leaders should be increasingly involved in the response with more visible HIV-positive church/faith leadership at all levels in interaction with secular HIV-positive leaders (FBO constituency). The FBO constituency pointed out that FBOs can facilitate operations research to provide essential evidence especially for prevention interventions at local, national and even supranational levels. Faith-based leaders can serve as vital advocates for new responses (FBO constituency). FBOs can contribute with the specific role the

churches have at local, national, regional and international level. However, in order to lead, the FBOs need to see their own potential more clearly (FBO constituency).

Involvement of marginalised groups was mentioned by many consistencies as an essential component in the fight against AIDS. The young people constituency pointed out the need to build leadership capacities among all groups (young people, PLHIV, sexual and gender minorities, sex workers, drug users, health care professionals) so that they can contribute meaningfully to the response., Marginalised and infected people as active agents of change and leadership should be put in the hands of these agents. Leadership needs to be generated from the ground-up (FBO constituency). Need “Legacy Building Leadership” (FBO constituency). The need for leaders’ representative of diverse populations affected by AIDS was mentioned as critical, not only “experts” (young people constituency).

The involvement of community and civil society was highlighted by several of the consistencies: community-level leadership will play a key role in the success to combating stigma, discrimination and other socio-cultural obstacles to achieving universal access (prisoners’ constituency). The FBOs mentioned that there should be an increase in community-led responses as opposed to organisationally-implemented “community-based” interventions.

The MSM constituency pointed out that civil society leadership and advocacy is particularly important. More attention needs to be placed in ensuring inclusiveness of civil society to ensure that needs of key populations (especially vulnerable groups) are addressed. The women constituency highlighted the need to mobilise an array of political, social, cultural and media leaders worldwide to promote and support actions to protect and promote girls’ and women’s health and human rights and to end HIV/AIDS. More advocacy efforts are needed in order to involve the other sectors to be active in the HIV response. Involve people at grassroots level in all decisions affecting their health (MSM constituency).

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