UNAIDS PROGRAMME COORDINATING BOARD

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Agenda item 3

Report on the consultative process to update and extend the UNAIDS 2011-2015 Strategy through the fast track period 2016-2021

Multi-stakeholder Consultations, January through April 2015
Compilation of Discussion Notes

Contents

OVERVIEW

As requested by the UNAIDS Programme Coordinating Board, UNAIDS has undertaken several months of consultation with the range of stakeholders involved in the AIDS response, in all regions, and via several methods. The overall aim of the consultation process on the UNAIDS 2016-2021 Strategy is to arrive at a shared understanding of where the AIDS response has succeeded and where challenges remain. The process further seeks to collectively define what must be achieved by 2021, what must be done differently to get there and how the Joint Programme can best lead and support accelerated progress.

The Joint Programme's approach to consultation has been guided by the principles of transparency and participation. In this regard, efforts have been made throughout the consultation process to reach out to and engage a diverse range of stakeholders, paying particular attention to engage networks of people living with HIV, Member States, civil society including organizations representing young people, women and girls and key populations, international and regional organisations and to do so in collaboration with the Cosponsors.

Multi-stakeholder consultations have been held at national, regional and global levels, in-person and online. A discussion paper, entitled "Getting to zero: How will we Fast-Track the AIDS response?", served to provide background information and questions to guide all consultations (available on the UNAIDS PCB page). Each consultation sought to answer the following questions (with some variation, as circumstances dictated):

1. How will developments – global and regional – impact the epidemic and response in countries and at the sub-national level over the coming years?
2. Who is being left behind and why? Where are the main challenges and gaps? What achievements in addressing challenges to date should be expanded and built upon?
3. In order to reach the Fast-Track targets, what should be the strategic priorities in the response?
4. What will need to change in support of those priorities? What are the "game-changers" – in terms of policy and law reform, funding, resource allocation, partnerships, service delivery, empowering civil society, science and innovation, and links with other health and development efforts?
5. What are the most critical ways in which the UNAIDS Joint Programme can support efforts to end AIDS as a public health threat by 2030?

This document consists of 12 Consultation Discussion Notes. These Notes seek to present a succinct and action-oriented summary of each consultation. Many were circulated to respective participants as drafts for input and review prior to finalization.

Regional consultations

UNAIDS Regional Support Teams led consultations in the seven UNAIDS regions. In addition, consultations were organized for North America and Western Europe and Other Countries. Regional notes were prepared by the UNAIDS RSTs and Liaison Offices.

1. Latin America
2. West and Central Africa
3. Middle East and North Africa
4. Washington DC
5. Caribbean
6. New York
7. East and Southern Africa
8. Asia and the Pacific
9. Western Europe
10. Eastern Europe and Central Asia

Global consultation

A multi-stakeholder global consultation was held in Geneva on 22-23 April 2015. With engagement from some 50 Member States, 11 Cosponsors and 4 PCB NGOs, the consultation brought together stakeholders for an interactive discussion on how to address challenges, define priorities, seize game-changers and accelerate action so as to reflect these in the UNAIDS 2016-2021 Strategy. The global consultation note was prepared by a consultant who attended the consultation.

Virtual consultation

In parallel with regional consultations, the first of two global virtual consultations was organized to encourage open and interactive discussion including with stakeholders who might otherwise not be reached. The consultation, held 23 March-2 April, generated a lively debate with over 280 inputs received from 50 countries in 5 languages. The virtual consultation note was prepared by a consultant who also monitored and moderated the consultation.

*Note that the opinions and recommendations expressed in the Consultation Notes are those of the diverse set of stakeholders consulted, and do not necessarily reflect the position of UNAIDS.

Discussion note
Regional Consultation on the UNAIDS Strategy 2016-2021:

LATIN AMERICA

February – March 2015

> *"The most subtle form of criminalization is discrimination"*
> *"We need to learn to talk about AIDS not as a problem itself but as an indicator of social problems"*
> *"Homosexuality does not need to be cured, homophobia does!"*
> *"In our urgency to respond we must not forget the inequalities that exist"*
> *"We should not wait for scientific progress to trickle down to the poor"*
> *"Collaborating entities should not become competing entities"*
> **Regional consultation participants**

Key Messages on UNAIDS Strategy

- The UNAIDS Strategy should be aligned with the **post-2015 development agenda**.
- **Sustainability** of the response will be key to achieve goals, in particular through increased allocation of domestic resources to prevention.
- **Human rights and gender** must be at the heart of the HIV response.
- **Latin America's leading role** in the HIV response needs to be visible and recognized. The region should further **develop and share knowledge** about the epidemic, its drivers and actors.
- **Health and other social services need to be redesigned** to promote integration and synergy, rather than competition for resources, as well as to promote the role of civil society in service delivery.
- **Stronger links are needed between HIV and other priorities** such as social and economic inclusion of indigenous populations, gender equality, gender-based violence, and drug abuse.
- **Innovative prevention methods**, including combination prevention strategies, need to be adopted to reduce new HIV infections.
- **New actors** such as local governments have to be brought on board in national HIV responses.
- Quality of **strategic information** should be improved at all levels.
- We need new persuasive arguments to secure **high level commitment** to the response.

Summary and Consultation Methods

A series of regional, sub-regional and country consultations took place during a period of one month. All groups responded to five questions outlined in the consultation guidelines. For Q1 most groups agreed that developments impacting the epidemic and the response could be grouped into political, economic and social developments, as well as developments in the HIV epidemic and the response.

Groups agreed that for Q2 that there are remarkable results in the region to build on; specifically in the areas of economy, health systems and society. However challenges and gaps identified in those areas confirm that there is still a long way to go.

In Q3, strategic priorities for the region were highlighted in the areas of law and policy, health systems and civil society involvement. Based on the group discussions around Q4

these strategies should take into account 8 clusters of game-changers in the response to HIV. These clusters are policy and law; service delivery; civil society; funding and sustainability; resource allocation; science and innovation; partnerships; and links with other health and development efforts.

In response to Q5 the groups call on UNAIDS to support the following: Accelerate progress in expanding treatment access (e.g. test and treat policy); Reinforce the leadership role of governments and the importance of their responsibility and accountability in the protection of human rights; Strengthen development of strategic information to inform policy and programmes; and Redesign health services and other services to generate synergies to keep people healthy, making sure civil society has full participation in service delivery to ensure that people living with HIV are linked to services at each step in the continuum of care.

Five Consultation Questions: Discussion Summary

1. HOW WILL DEVELOPMENTS – GLOBALLY AND IN THE REGION – IMPACT THE EPIDEMIC AND RESPONSE IN THE REGION, SUB-REGIONS AND SPECIFIC COUNTRIES OVER THE NEXT SIX YEARS?

The different groups analyzed how developments in the areas of politics, economy, and civil society in relation to HIV will impact the epidemic and response in the region.

Political developments. There is a lack of high-level multisectoral political commitment to the HIV response, with some exceptions. This discussion must be addressed in the framework of the post 2015 agenda, where HIV is losing priority. Highly conservative political and social trends threaten to reverse achievements in recognition of human rights. Despite the available evidence, clear policies and programmes tailored to the needs of key populations do not exist. Legal frameworks exist but are not implemented and still pose legal barriers to key populations, including punitive laws and criminalization of HIV transmission and sexual diversity. The growth of urban populations poses further risks and challenges. Decentralization of HIV services in most countries of the region puts cities and local governments at the centre of the response. The priorities and specific interests of Latin America must be more visible in the updated and extended UNAIDS Strategy if it is to be global.

Economic developments. The region has experienced rapid economic growth, which has reduced poverty and vulnerability, but Latin America is still the most unequal region in the world. Growth will slow down, risking sustainability of achievements. There are few South-South cooperation strategies. National domestic resources are mainly allocated to ART. New trade agreements might impact access to ARV. The world tends to concentrate aid resources in Africa rather than addressing the inequalities that exist in MICs in Latin America. The governments of the region are strengthening commercial ties with the Asia-Pacific region, as China is soon expected to become the second most important commercial partner.

Social developments. Implementation of social protection policies is key to keeping people living with HIV alive. High levels of generalized violence in Central America and gender-based violence all over the region disproportionately affect young people. Machismo is prevalent across the region, leading to discrimination of people of sexual diversity. Economic growth is driving migration among and within countries. There are some tensions between human rights and multiculturalism. Respect for cultures should be conditional to respect for human rights. Indigenous populations continue to be marginalized from political engagement

and social services. The region is facing changes in the pattern of drug use from injecting to non-injecting use.

Developments in civil society. Civil society is increasingly active but tends to get bogged down in bureaucratic processes, and activism is waning. CSOs have less time to focus on their watchdog and advocacy roles, as they are focused on implementation of GF grants. Civil society still lacks sufficient coordination with governments. LGBT groups are shifting their area of interest from HIV to human rights.

Developments in the HIV epidemic. Life expectancy is increasing. Stock-outs of ARVs threaten treatment adherence. Late diagnosis and loss of patients to follow-up in the continuum of care are challenges in maintaining the health of people living with HIV. Migrants and indigenous populations are considered populations left behind – with little evidence on their vulnerability and access to services. Concerns have been voiced about the increased medicalization of the response.

2. **WHAT ACHIEVEMENTS OF THE REGIONAL RESPONSE SHOULD BE EXPANDED AND BUILT UPON? WHERE ARE THE MAIN CHALLENGES AND GAPS? WHO IS BEING LEFT BEHIND AND WHY?**

The consultations identified 3 categories in which results, challenges and gaps should be highlighted.

Social and legal

Results
- Protective laws (LGBT rights-gender identity)
- Recognition of the role of people living with HIV and key populations in the response

Challenges and gaps
- Lack of high-level political commitment to the response
- Fundamentalist movements could threaten democracy
- Harmful gender norms in a context of poverty and legal and social inequalities
- Criminalization of transmission of HIV and of sexually diverse behaviors
- Adolescents lack legal support to access HIV services
- Lack of monitoring of access to justice
- Need for greater efforts in sharing knowledge
- Weak multisectoral links (education, labor, justice, social protection)
- Civil society highly fragmented and bureaucratized, distracted from advocacy as they are focusing on project implementation; lack of new leadership in civil society
- South-South cooperation needs to be further promoted

Health dimensions and health systems

Results
- Increased access to ARV and increased adherence rate
- Reduction in MTCT
- Increased condom use in key populations
- New testing strategies for key populations
- Growing synergies between SRH and HIV services
- Effective participation of civil society
- Health systems strengthening
- Scale-up of HIV/TB collaboration

Challenges and gaps

- Some key populations are being left behind. Children are still being infected despite efforts to ensure access to PMTCT. Adolescents still lack access to HIV testing and countries have failed to deliver school-based sexuality education despite commitments. Women do not find gender-sensitive services for HIV. Prisoners lack access to basic health services. FSW, MSM, transgender women and drug users (including non-injecting drug users) face discrimination and stigma in services that don't respond to their specific needs. Migrants (including migrant sex workers) lack access to services. Indigenous peoples and people in poverty often do not have access to health services and face cultural barriers.
- Greater and deeper knowledge about HIV epidemic and the response is needed. Knowing who the key populations are, how many are they, where they are, which are their behaviors, and their barriers to access services. More operational research and disaggregated data. Longer life expectancy increases the likelihood of experiencing barriers to healthcare and to social exclusion.
- Acknowledgement that access to services means not only that they are available but respecting the dignity and rights of the people that need them
- Decentralization and community-based services still weak and unsustainable
- Lack of definition of the role of civil society in service delivery
- Costly supply chains and recurrent stock-outs

Economy

Results
- Movement towards sustainability

Challenges and gaps

- The region must have improved access to global funding for AIDS and health, as well as explore new opportunities, e.g. BRICS
- Sustainability will also depend on increased allocation of domestic resources in all countries especially in prevention
- High out-of-pocket expenditures
- Access to public funds for civil society still very limited
- Trade agreements can affect access to ARV and other commodities; Need to more effectively use TRIPS flexibilities to reduce commodity prices and increase access to ARV

3. IN ORDER TO REACH THE FAST-TRACK TARGETS, WHAT SHOULD THE REGION'S STRATEGIC PRIORITIES IN THE RESPONSE BE?

The group of regional stakeholders reviewed the strategic priorities of the current strategy in the light of the new developments and agreed that no fundamental changes should be made. The group identified the following strategies as priority:

Law and policy

- The response should be tailored to each context. Countries' ownership of the response has to be strengthened. As such, a persuasive argument should be constructed using pathos, ethos, funds and votes to convince decision makers.
- Reduction of homophobia and transphobia (including same-sex marriage and gender identity laws)

- Articulation of HIV and human rights agendas, including ensuring that health is recognized as a human right in every country and not left at the State's will or to market regulations.
- HIV transmission and sexual diversity should be decriminalized, and sex work and drug use should be regulated based on human rights.
- Gender-based violence needs to be addressed through effective responses
- Regional and sub-regional integration is a must, not only to increase availability of resources but to strengthen cooperation. Together the region must pursue uniform ARV prices among countries for an effective regional response. The Global North should not be excused from its duty to cooperate.
- Latin America, its countries and actors should take their AIDS responses out of isolation. Multisectoral responses should be promoted, including closer partnerships between local governments and the private sector to strengthen HIV prevention. Stronger links are needed between HIV and other areas such as indigenous populations, gender equality, gender-based violence, and drug abuse. Health and social services have to be integrated and not compete for resources.
- Systematization of findings and lessons learnt with capacity building to apply these lessons.

Health and health services

- Strengthen health promotion strategies
- Reduce new infections. Strengthen collection and knowledge of baseline data.
- Boost use of innovative prevention method (PrEP) for key populations
- Improve achievements in treatment (test and treat)
- Emphasize the leading role of governments and call for accountability
- Strengthen epidemiological surveillance systems to collect more disaggregated data and ensure evidence-based interventions.
- Redesign health and other services to generate synergies and include key populations. Allow civil society to navigate people living with HIV across health services.
- Avoid stock-outs of ARV and other commodities.

Civil society and populations

- Civil society organizations should be placed at the center of the response and their institutional sustainability has to be ensured.
- Training of civil society in judicial grievances including facilitating access to legal services
- Promoting dialogue with churches as opinion leaders
- Focus on urban marginalized populations
- Implementation of multicultural strategies for indigenous and migrant populations
- Activism should be promoted. Activists, not bureaucratic processes, should be the protagonists.

4. **WHAT WILL NEED TO CHANGE IN SUPPORT OF THOSE PRIORITIES? WHAT ARE THE "GAME-CHANGERS" – IN TERMS OF POLICY AND LAW REFORM, FUNDING, RESOURCE ALLOCATION, PARTNERSHIPS, SERVICE DELIVERY, EMPOWERING CIVIL SOCIETY, SCIENCE AND INNOVATION, AND LINKS WITH OTHER HEALTH AND DEVELOPMENT EFFORTS?**

Eight categories of game-changers were highlighted by the various groups through the process. Detailed action areas for each game-changer follow.

Policy and law

- Tensions addressed between human rights and multiculturality
- Increased understanding of gender mainstreaming. Gender focus in the response to HIV is not negotiable; human rights of LGBTIQ must be respected. All types of violence have to be eliminated, including institutional and symbolic violence.
- Strengthened knowledge and sharing of knowledge of the epidemic and its drivers – operational research
- Positioning of Latin America in global discussions
- Respect for human rights, including access to test and care by adolescents, prisoners, socially marginalized populations and LGBTI groups
- Regional and sub-regional integration
- Universal health care
- Increased government accountability on respect for human rights and monitoring of governmental commitments

Service delivery

- Involvement of civil society in service delivery (task shifting)
- Services for key populations, including training of health personnel
- Monitoring the quality of services
- Prevention and treatment of co-infections
- Mainstreaming of HIV in primary health care
- Efficient referral systems
- Efficient supply chain management systems
- Integration with social protection and justice delivery services for all key populations

Civil society

- Empowerment and involvement of civil society in the design and implementation of the response
- Involvement of young people in the response
- Increased capacities for advocacy
- Promotion of new leadership
- Promotion of true activism
- Monitoring judicial grievances

Funding

- Domestic funding allocated to prevention for key populations (sustainability)
- Increased South-South cooperation
- Use of TRIPS exceptions to maximize investments
- Public-private alliances

Resource allocation

- Evidence-based resource allocation
- Resources for prevention and sexuality education
- More efficient distribution of global aid
- Responsibility of the North towards Latin America
- Domestic funding for strategic information
- Prices of ARVs for prevention (PrEP)

Science and innovation

- Anthropological studies to inform the response
- Operational research
- Adoption of new technologies for early HIV diagnosis
- Existence of mechanisms to access and use innovative technologies
- Involvement of science and technology public sector in the response

Partnerships

- Ownership of the response by local governments.
- Increased coordination between governments and civil society
- Commitment of the private sector to better implement workplace policies and corporate social responsibility

Links with health and development efforts

- Integration with poverty reduction, gender-based violence and gender equality initiatives
- Social protection for people living with HIV and key populations

5. **WHAT ARE THE MOST CRITICAL WAYS IN WHICH THE UNAIDS JOINT PROGRAMME CAN SUPPORT EFFORTS IN THE REGION TO END AIDS AS A PUBLIC HEALTH THREAT BY 2030?**

- Provide guidance to significantly reduce the number of new infections. The baseline needs to be known. The epidemic continues and we need to make sure everyone is sufficiently empowered and protected so as to not be left behind.
- Accelerate progress in expanding treatment access. Coverage goals need to be rethought to include test-and-treat policies to keep PLHIV healthy and prevent transmission. ARV prices must be decreased using TRIPS legislation. Adherence support programs need to be scaled up.
- Urge governments to take responsibility and accountability for the protection of human rights.
- Strengthen strategic information collection systems to ensure information is granular and disseminated.
- Redesign health services and other social services (education, sexuality education, gender-based violence, unemployment, etc.) to generate synergies to keep people healthy, advocating for civil societies full participation in service delivery and supporting affected communities to have a role in service provision and help people navigate services.
- Division of labour among UNAIDS cosponsors should be strengthened.

LATIN AMERICA: CONSULTATION METHODOLOGY

An inclusive regional consultation for the update of the UNAIDS Strategy 2016-2021 in Latin America was planned as a multi-phase and multi-level process by the RSTLA. Meetings with Regional Key Stakeholders, UNAIDS co-sponsors, Sub-regional stakeholders and national consultations took place over the period of one month (February 23rd-March 24th).

An innovative communication technology was set and consultations were conducted utilizing the UNAIDS WebEx platform; ONUSIDA Latina webpage; Social Media (Facebook and Twitter) and Livestream-webcast with multi country connection with open chat to the region. The regional consultation started with an in house exercise with an in presence meeting with Regional Cosponsors (UNAIDS Regional Cosponsors Group for Latin America) and with RST and all country offices staff. It finished with a High Level webcast virtual meeting (New York-Geneva-Brasilia-Asuncion-Buenos Aires-Panama City) followed by more than 150 people from the Region.

IN PERSON CONSULTATIONS: The process started with a 2-day consultation with the UNAIDS Coordinating Regional Group Meeting. HIV Regional Advisers from PAHO/WHO, UNDP, UNESCO, UNFPA, UNICEF, UN WOMEN and WFP attended the in-personmeeting.

A selected group of Think Tank stakeholders met in Panama in late February to participate in the construction of Political Scenarios for the AIDS Epidemic. A one day-meeting was held to open discuss the update of the UNAIDS Strategy for 2016-2021.

VIRTUAL CONSULTATIONS: UNAIDS held two regional, four sub regional and two country consultations by WebEx and opened a survey on the ONUSIDA Latina webpage to gather inputs from the region. The first regional meeting was open to participation from all country offices, and the second was a public meeting with participation from all countries, representatives from governments, civil society, academia, people living with HIV and other actors.

Four additional Webex meetings took place to gather input from the sub-regional stakeholders: Two for Central America, one for the Andean Region and one for the Southern Cone.

Two key countries from the Region asked UNAIDS RSTLA to hold separate in-country consultations – El Salvador in Central America and Brazil in South.

Webcast with the participation of Dr. César Núñez, Director UNAIDS RST LA and Mrs. María Cristina Perceval, Representative of the Permanent Mission of Argentina before the United Nations. 24 March 2015.

Ilustración 1. Meeting calendar for the regional consultation in Latin America to update the UNAIDS Strategy for 2016-2021

Finally a regional high-level webcast utilizing Livestream technology (including presentations from the UN Ambassador for Argentina, the regional CSO delegate in the UNAIDS PCB and the GFATM delegate for Latin America) was broadcasted on 24 March 2015, followed online by more than 150 participants from all countries in the region.

All reports follow the template provided and inform the final report of the consultation.

HIGH-LEVEL WEBCAST

1. Sra. María Cristina Perceval, Representative of the Permanent Mission of Argentina to the United Nations
2. Dra. Mirta Roses, Miembro de la Junta Directiva del Fondo Mundial para América Latina y el Caribe
3. Dr. Fernando Lavandez, Asesor especialista en salud, nutrición y población para América Latina y el Caribe, Banco Mundial
4. Dr. Rafael Mazín, Asesor Senior de VIH, Hepatitis, Tuberculosis e ITS de la OPS/OMS
5. Sr. Simón Cazal, Delegado LAC en el PCB de ONUSIDA
6. Dr. Fabio Mesquita – Director del Depto. de ITS, SIDA y Hepatitis Virales de Brasil
7. Dra. Tatiana Berardo, Depto. de ITS, SIDA y Hepatitis Virales de Brasil
8. Sra. Ana Melissa Rojas, Subdirectora de Gestión Social de la Alcaldía de Panamá

Discussion note
Regional Consultation on the UNAIDS Strategy 2016-2021:

WEST AND CENTRAL AFRICA

February – April 2015

KEY MESSAGES ON UNAIDS STRATEGY

- HIV prevention, treatment, care and support is still an **"unfinished business"** in the region. The positioning of HIV in the post-2015 agenda and the SDGs will be critical in mobilizing political and economic commitment to HIV.
- Evidence-based innovative programs and integrated service delivery models **for adolescents, young women and girls and key populations** that include social protection components are urgently needed - especially in Fast-Track countries in the region.
- Prevention of new HIV infections among children can be accelerated by **integrating PMTCT** into the minimum package of maternal and newborn child services.
- **Inclusion of community stakeholders** and all those left behind (children, sex workers, MSM, PWID, vulnerable women and girls, youth, prisoners, PLHIV, etc.) should be a top priority.
- **Health and community systems** must be strengthened – including through decentralization, task-shifting and integration of HIV services with other chronic diseases and sexual and reproductive health platforms.
- **HIV commodity security** is a critical concern – solutions must be found, including through south-south cooperation, to both scale up local production of medicines and significantly reduce the price of commodities.
- **Removal of punitive laws** against PLHIV and key populations and addressing structural barriers to reduce stigma, discrimination and gender-based violence is necessary to create an inclusive and enabling environment for the AIDS response.
- Strengthening the **generation of strategic information** to track HIV program response is essential to guide evidence-based planning and policy making as well as ambitious target-setting.
- UNAIDS must support the reinforcement of **country leadership and ownership** – especially at subnational levels in the context of shared responsibility and global solidarity. The need to tilt the balance between domestic and international funding for HIV programs in the region to ensure sustainability has become more important than ever.

EXECUTIVE SUMMARY AND CONSULTATION METHODS

The consultations in West and Central Africa (WCA) Region were conducted via a bottom up approach starting from the country level and led by the UNAIDS Country Offices with oversight and technical guidance from the Regional Support Team in Dakar. The UCOs used existing national coordinating mechanisms, UNCT, UN Joint Teams on AIDS, and Expanded Theme Groups to broadly engage multi-lateral and bi-lateral agencies, country governments, civil society including youth organizations, networks of persons living with HIV, the private sector and representatives of people left behind (MSM, FSWs, PWIDs, adolescents and vulnerable women and girls).

The RST leveraged the support of the expanded Joint United Nations Regional Team on AIDS (JURTA) to engage thematic groups discussions on prevention, treatment and human

rights and gender and to thoroughly respond to all the standard questions for updating the UNAIDS Strategy 2016-2021. The RST further engaged youths and civil society organizations in the region via survey monkey to solicit broad ideas from these constituencies. Particular efforts were made to build on previous regional consultations on re-targeting and post-2015 consultations. All these inputs were further reviewed and synthesized during a JURTA retreat for a consolidated input to update the strategy represented by this report.

Finally, a 2-day regional consultation was organized on the 1st and 2nd April, 2015 on the UNAIDS Strategy with a total of 60 participants from Government Ministers, heads of National AIDS Councils, Civil Society Organizations, youth groups and International NGOs (e.g. MSF/IFRC).

The objective of the meeting was to solicit inputs on regional achievements and challenges, regional strategic priorities and major game changers which are key to fast tracking and laying the foundations for ending the AIDS epidemic in the WCA region by 2030. Feedback from this meeting has informed this final report articulating the regional priorities for WCA to be incorporated into the UNAIDS Strategy 2016-2021.

The consultations were conducted via four main groupings to review and respond to the standard questions used to guide the update of the Strategy:

- Prevention revolution
- Treatment care and support
- Human rights and gender
- Cross-cutting: Country ownership, leadership and sustainability and what UNAIDS can do help the region fast track.

This note is drawn from a more comprehensive report on the regional consultation, a copy of which can be requested from the West and Central Africa RST.

FIVE CONSULTATION QUESTIONS: DISCUSSION SUMMARY

1. **HOW WILL DEVELOPMENTS – GLOBALLY AND IN THE REGION – IMPACT THE EPIDEMIC AND RESPONSE IN THE REGION, SUB-REGIONS AND SPECIFIC COUNTRIES OVER THE NEXT SIX YEARS?**

- Growing insecurity, terrorism in the sub-region due to armed conflicts, political instability and civil strife, environmental degradation and food crisis and their resultant humanitarian crises accentuate human rights abuses, sexual gender-based violence and vulnerability to HIV, particularly among women and girls.
- Emerging and re-emerging diseases have become more devastating because of weak health systems in the region. The emergence of epidemics like Ebola exposed chronic weaknesses in the health systems and has devastated a range of systems and their human resources. Natural disasters and the rise of non-communicable diseases will impact the HIV response within a context of an ongoing brain drain of qualified African professionals in various fields, as well as governance issues in health systems management (poor prioritization of problems, corruption and inadequate accountability) and lack of investment into addressing major challenges.
- The positioning of HIV in the post-2015 agenda (Sustainable Development Goals) is going to be a critical factor in mobilizing political and economic commitment to HIV as an unfinished business even though significant progress has been made.

- Increased South-South cooperation and collaboration with the BRICS countries (Brazil, Russia, India, China and South Africa) is needed especially to accelerate capacity development for local production of affordable medicines in Africa.
- Demographic challenges in WCA including a 17% population growth over the 2015 population i.e up to 2.6% per year in WCA by 2030 (State of the World's Children, 2015) will also require an augmentation of resources to tackle the HIV epidemic. Growing urbanization will result in an increasing concentration of the HIV epidemic in cities, which presents an opportunity for a targeted response. More in human capital investments will be critical to transform the demographic dividend into socio-economic advancement for countries.
- Macroeconomic factors: Economic growth will continue but with huge inequitable distribution of wealth and dependency ratio. There will be the emergence of a new wealthy class and philanthropic sector which if leveraged strategically will increase domestic funding sources.
  - o However, the growing gap between rich and poor may lead to increased vulnerability and risk of exposure to HIV infection especially for women and girls. Furthermore, given the high level of donor dependency, the financial crisis has had a negative impact on external and internal resource mobilization in the region.
  - o Looking ahead, direct global funding for AIDS will likely decline, particularly given the range of emerging health and development priorities.
  - o Stronger country ownership of the HIV responses is an urgent need. More domestic funding that is front-loaded, efficiently and effectively utilized; stronger community and health structures; public-private-partnership; and accountability will dramatically shift the dynamics of the epidemic.
  - o However, persistence of the current macroeconomic factors may negatively impact availability of public and private funds: e.g. drop in the global commodities prices for crude oil especially in oil producing economies, inadequate private sector investments, weak capacities in local pharmaceutical production, skewing of mining contracts amidst the current gold rush caused by the flowering of mining sites to the disadvantage of communities and countries.
- Leveraging of Technologies: The increasing role of ICT and social media platforms will continue to impact the region significantly and these can be strategically tapped to mobilize more domestic resources for the HIV response, or used as a platform for community engagement and improvement of service delivery.
- Inadequate progress on an enabling legal and human rights environment is negatively impacting the HIV response. Laws and regulations on 'age of consent' for accessing services (testing, treatment, family planning) are important bottlenecks in the current response. The elimination of punitive laws and introduction of protective laws for key and vulnerable populations will most likely contribute to diminishing stigma and discrimination, as well as empowering these groups and promoting gender rights through positive social and gender norms.

2. **WHAT ACHIEVEMENTS OF THE REGIONAL RESPONSE SHOULD BE EXPANDED AND BUILT UPON? WHERE ARE THE MAIN CHALLENGES AND GAPS? WHO IS BEING LEFT BEHIND AND WHY?**

A summary of the key achievements and gaps that must inform the next UNAIDS strategy are as follows:

- Although there has been some improvement in the coverage of PMTCT, this is not enough to eliminate mother to child transmission of HIV. There is the urgent need to adopt Option B+ and rapidly scale-up and integrate Option B+ into RMNCH services delivery in all WCA countries.

- Populations being left behind merit more explicit inclusion in National Strategic Plans. Populations include: Children, adolescents, young people, women, MSM, IDUs, FSWs and their Clients, People affected by humanitarian crises, migrant and mobile populations.
- Inter-governmental and cross-border programs should be further leveraged for the AIDS response, e.g. the increasing involvement ECOWAS/WAHO in pharmaceutical production and medicines regulations in West Africa; and ALCO, Mano River Union, FEVE-Enda santé to strengthen HIV interventions targeting mobile vulnerable populations.
- Health and community systems must be strengthened, including by addressing human resources, weak M&E systems and poor procurement and supply chain management. The inclusion of communities as active actors and not passive recipients of services has been key to success in the response to date, and must be built upon. The role of the private sector in HIV service delivery must be scaled up.
- Decentralization of services and the elimination of cost as a barrier, including by ensuring free HIV services where necessary, is critical to rapidly expand access.
- Social Protection programmes have been a huge achievement in the region, yet implementation in the field is not always effective and the advocacy for HIV-sensitivity remains a priority.
- Proven prevention technologies must be leveraged as much as possible; gaps in HIV education, testing and condom access for young people must be closed.
- There has been a progressive increase in the number of people on HIV treatment from about 6,000 in 2003 to almost 1.4 million in 2013. However, this only represents 23% of PLHIV in need. Pediatric ART coverage remains disproportionately lower. Low treatment coverage may be linked to the hyper medicalisation of service provision, the low engagement of men in treatment, care and support, lack of funding for food and nutritional support as well as weak integrated management of comorbidities (HIV, TB and Hepatitis).
- Gender and human rights issues must be maintained as a priority at national, regional and international levels and address aggressively the challenge of stigma and discrimination. Structural challenges limit the response including: unfavourable social norms, legal environment (punitive laws, lack of knowledge of rights and enforcement of positive laws, abuses), policies and funding; and criminalization of sex work, drug use and same-sex behaviour. Intergenerational sex between young girls and older men remains a key driver to the epidemic and efforts to address it need to be linked up with school and poverty programmes.
- Effective participation of vulnerable groups is critical in the design of programs and in the fight against all forms of discrimination particularly women and girls, and young people.
- Important data gaps remain, particularly on modes of transmission, vulnerable and key populations, gender-based violence and limited gender, age, and localisation.

3. IN ORDER TO REACH THE FAST-TRACK TARGETS, WHAT SHOULD THE REGION'S STRATEGIC PRIORITIES IN THE RESPONSE BE?

a) Fast track high impact prevention and treatment interventions and address issues related to human rights and gender inequality
  - Fast tracking (90-90-90) needs to be a political issues to ensure that the needed resources and investments are front-loaded to optimize the impact of the HIV response
  - The adoption of location/population strategy into national strategies and operational plans to address needs of populations being left behind (children, young people, women/young girls, sex workers, MSM, PWID, migrants, prisoners etc)
  - Adoption of Cities and HIV Initiatives: Use the Municipal, cities and communities approach to address local epidemics

- Strengthening of Ministries of Women or Social Affairs and to increase their coordination/collaboration with the Ministry of Health
- Prioritizing the response to humanitarian crisis in countries that are in-and-out of conflicts as well as fragile states.

b) Allocate available and future resources towards test, treat and retain interventions (i.e. 90-90-90) to cover all HIV positive pregnant women and their children, people left behind including key populations, and sero-discordant partners through a systematic scale up of HIV interventions throughout the health services delivery hierarchy and in the non-health sector and also by invigorating social and behavioural change

c) Strategically engage the private sector in the national HIV response and establish more Private-Public Partnerships for sustainable health impacts

d) Strengthen health, social protection and community systems as well as integration of services to:
- Leverage short-term and long-term technical support to strengthen systems for implementation of programs for impact
- Strengthen comprehensive health system for HIV as a chronic disease including other co-morbidities for PLHIV and key populations and new service delivery models for one-stop-shop and integrated multi-diseases screening; Increase capacity for integrated health services delivery and health management information at lower levels
- Innovate health service delivery by task-shifting and strengthening the linkages between health and community service platforms to ensure that services are brought to the door-steps of people for example through the Family-Centred Approach
- Capacity building of health and non-health/community actors, including faith-based, in quality health service delivery, human rights and gender
- Focus on laboratory services to be available at the decentralized level (point of care for viral load and CD4 monitoring)
- Focus on addressing legal and social environment by building capacity of key personnel in human rights and gender and the legislative branches and by engaging men and boys in these issues
- Sexual and reproductive health education for all young people in-and-out of school

4. **WHAT WILL NEED TO CHANGE IN SUPPORT OF THOSE PRIORITIES? WHAT ARE THE "GAME-CHANGERS" – IN TERMS OF POLICY AND LAW REFORM, FUNDING, RESOURCE ALLOCATION, PARTNERSHIPS, SERVICE DELIVERY, EMPOWERING CIVIL SOCIETY, SCIENCE AND INNOVATION, AND LINKS WITH OTHER HEALTH AND DEVELOPMENT EFFORTS?**

a) Investment and efficient and effective use of resources: From both local and external sources in line with shared responsibility and global solidarity
- Strengthen domestic and local resource mobilization: Public-Private Partnerships and taxes, mobile telephony, alcohol, plastic bags etc.
- Leveraging opportunities from environmental assessment of large capital infrastructure projects, which by law, requires proponents - governments, private sector; to assess all the environmental and social impacts and formulate costed mitigation plans to minimize any known negative social (Health, HIV, Gender) impacts. Also through Corporate Social responsibility.
- Institutionalize the effective involvement and participation of stakeholders (youth, women, sex workers, MSM, PWID, PLHIV etc) at any scale of development of prevention strategies in their implementation and evaluation (community observatories)

- Focus, Focus, Focus on programming
- Integrate HIV programming into overall sectoral programming; move towards sector-wide performance funding of integrated services

b) Engage range of local and community leaders to strengthen health and community systems
   - Mobilize and involve local authorities (mayors), local leaders and private sector with a focus in the most affected areas (analysis of the situation at the local level, strengthening accountability, mobilizing partners and resources)
   - Increased civil society engagement and advocacy at all levels including community service delivery; Community HIV Testing, self-testing and ARV delivery services at the door steps of people as well as community health workers to help improve adherence and retention in care and treatment
   - Working with Imams and pastors and putting HIV testing services in mosques and churches; Active engagement of grandmothers/parents in sexual health education for children, adolescents and young people

c) Promote equitable access to HIV services through economic support and reducing costs
   - Establish social protection programs which are HIV sensitive
   - Promote Universal Health Coverage implementation
   - Elimination of all user fees for HIV services, including condoms, lubricants and treatment
   - Advocacy for reduction of ARVs and testing costs, especially for paediatric and second-line drugs

d) Local production of ARVs, medicines regulations, fixed dose combinations, and addressing the issues of supply chain management in line with ECOWAS and AU initiatives
   - The BRICS countries have to play a significant role in the global AIDS response through increased South-South cooperation and collaboration especially regarding local production of medicines and using the TRIPS agreement
   - Local/regional investment in the supply chain mechanism and management for commodities: harmonisation of supplies (HIV tests) and pooled procurement of commodities and utilization of a regional Early Warning Systems for procurement and supply chain management
   - Promote Research and development
   - Leveraging the logistic and supply infrastructure of private businesses (e.g Coca-cola and telecom providers) as well as co-sponsors can help ensure commodity security at national and decentralized levels

e) Robust advocacy program to repeal punitive and discriminatory laws and practices against key populations
   - Laws reform in relation to human rights and gender literacy/norms and to improve access to legal aid and justice
   - Advocate for the Zero stigma and discrimination through the comprehensive implementation of the Anti-Discrimination Acts passed in many countries
   - Women empowerment (politically, legally, economically) and revision of discriminatory laws on aspects related to inheritance, the right to property, sexual and gender-based violence)
   - Eliminate punitive laws and decriminalize sex work
   - Capacity building for key national institutions, parliament, law enforcement, First Ladies and other champions in human rights and gender programming including Know-Your-Rights campaigns and related to reducing gender-based violence
   - Inclusion of Human Rights and Gender in schools curricula and e-learning

- Make gender and human rights issues electoral priorities

f) Evidence-informed policies and programs:
  - Adoption of Location-population approaches in national strategies and operational plans
  - Treatment of all children under 15 years with ARVs
  - Lifelong ARV Treatment for all HIV pregnant and breastfeeding women (Option B+)
  - PrEP or HIV treatment for couples in sero-discordant unions

g) Strategic use of ICTs, mobile technology and social media
  - Leveraging such technologies to mobilize all people left behind for HIV testing, knowledge dissemination and access to services as well as improvement in the quality of services (follow up, adherence etc). The use of drones to deliver commodities etc.
  - Revisit the current communication strategy on HIV and take advantage of ICT especially social media to create demand and to do focused advocacy.

h) Science and innovation and funding research for a cure and vaccine for HIV and improved delivery systems for ARVs
  - The design of PrEP as lipsticks (PrEP on one-side and lip-stick on the other) can be very attractive for young women
  - Use of science and Innovation to improve on delivery mechanisms for long acting ARVs e.g. design PrEP in a way that a single shot can last for at least 3-6 months

i) Linkages of health including non-communicable diseases with other development efforts

5. WHAT ARE THE MOST CRITICAL WAYS IN WHICH THE UNAIDS JOINT PROGRAMME CAN SUPPORT EFFORTS IN THE REGION TO END AIDS AS A PUBLIC HEALTH THREAT BY 2030?

Key messages:
- Support for the production of strategic information to better plan, better invest for greater impact
- Advocacy to mobilize greater resources to end AIDS
- Strengthening Civil Society
- Better coordination of the work of all partners
- High-level advocacy for HIV so that it remains in country priorities calendars

Specific roles for the UNAIDS:

a) **Coordination:**
  o UNAIDS to continue to support strengthening country systems for coordination of the AIDS response and also invest in building the capacities of National AIDS Commissions, Country Coordinating mechanism, Civil Society etc
    - Continue to support country systems through the ''three ones'' principles to ensure country ownership within the context of shared responsibility
    - Continue advocacy with the Government and co-sponsoring agencies of the United Nations System and all the partners for their continued commitment and alignment with the National Strategic Plans, M&E Plans and one coordination body
    - Strengthen the capacities of National AIDS Commissions, the Ministries of Health (resource mobilization, evidence-based planning, private-sector engagement, etc.)
    - Strengthening the institutional framework of the multi-sectoral response
    - Facilitate better working relationship between the Ministries for Health and CNLS by conducting an analytical study modeling

- Prioritize active engagement of its co-sponsors in the region

b) **Leadership and advocacy:**
o Sustain high-level political and implementation advocacy and support with Governments and leaders at the decentralized level
o Continue to be the voice of the voiceless and prioritize the populations being left behind especially women and young girls/adolescents, PLHIV, refugees and displaced people and key populations (Sex workers, Men who have sex with men, people who inject drugs, prisoners etc)
o Map and adequately build the capacity of institutions responsible for gender and Human Rights to better protect PLHIVs, women and girls and key population
o Support the development of robust communication plans to improve on messaging for demand creation for fast tracking the response
o Strategically provide political support for universal health coverage to take ''AIDS out of isolation''
o Focus on implementation more than planning
o Partner with key research and development institutions to develop a vaccine and cure for the HIV epidemic
o Strengthen UNAIDS capacities to better support Member States, as well as coordination capacity

c) **Commodity security:**
o Support Africa to produce quality ARVs locally in a cost efficient manner. This will ensure continued access to ARVs at reduced cost in the high burden regions
o Support the quality supply management system and quality of drugs: advocating for the necessary quantity of medications to be available in appropriate health facilities

d) **Strategic information:**
o Strengthen the generation of strategic information to track HIV program response and use data to set ambitious targets and also for evidence-based planning and policy making
o Be the global reference for AIDS data and therefore it must invest adequately in strategic information to help countries prioritize and gain greater return on investment for any resources invested into ending AIDS
o Continue to invest strategically in technical support to fast track the strengthening of health and community systems in the region
o Focus on strengthening community systems and empowering communities and civil society to better engage the health and other sectors for mutual benefits of ending AIDS
o Ensure that new technologies including mobile technology and social media are used to mobilize priority populations for fast tracking especially to address local epidemics.

e) **Resource mobilization and allocation:**
o Identify innovative ways of helping countries to mobilize local resources and invest those resources strategically for impact
o Develop tools and devise innovative ways to support countries to mobilize more domestic resources for fast tracking within the context of shared responsibility and global solidarity
o Optimize the use of tools for capturing unit cost for program effectiveness and efficiency studies
o Invest more in mobilizing national expertise than international consultants
o Promote the development and implementation of Medium Term Expenditure Frameworks related to AIDS
o At the global level undertake advocacy to simplify the implementation procedures of the programs funded by the Global Fund and PEPFAR

o Create a platform to coordinate innovative financing mechanisms and sustainability transition plans for the AIDS response at the country level
o Track government commitments and partner contributions

f) **Governance:**
o Improve governance and program management systems by supporting the establishment of risk management systems to ensure accountability at both national and sub-national levels to maximize impact of the interventions during fast tracking
o Make available to the countries tools to support good governance and transparency in program management
o Pre-empt the scenario of socio-political and health crisis in the planning of AIDS programs

WEST AND CENTRAL AFRICA: PARTICIPATING INSTITUTIONS

Belgium	Medecins Sans Frontiers
Burkina Faso	PAMAC/CSO
Burundi	Communications expert
Cameroon	National AIDS Council
Cameroon	Positive Generation (CSO)
CAR	National Coordinator
Congo	Department of Public Health and Population; National Council for the Fight Against AIDS
DRC	National Council for the Fight Against AIDS
France	Medecins Sans Frontiers
Ghana	Human Rights Advocacy Centre
Guinea	National AIDS Committee
Kenya	International Planned Parenthood Federation ARO
Mali	National AIDS Council
Mauritania	National AIDS Council
Niger	National Multisectoral Programme for the Fight Against AIDS
Nigeria	National Agency for the Control of AIDS (DG-NACA)
Suisse	International Federation Red Cross
Senegal	National AIDS Programme
	Office of the Mayor of Dakar
	Esther (Together for Hospital Solidarity Network)
	Finance Expert
	Youth Representatives
	Medecins Sans Frontiers
	HIV Medical Laboratory
Togo	Presidency of the Republic Multisectoral Coordination of the Fight against HIV and STIs

Discussion note
Regional Consultation on the UNAIDS Strategy 2016-2021:

MIDDLE EAST AND NORTH AFRICA

11 March 2015, Cairo

"Ending the AIDS epidemic as a public health threat in Arab Countries is possible and the updated UNAIDS Strategy is fundamental to achieving this vision, addressing the existing gaps and enhancing the AIDS response in the post-2015 development era. The League of Arab States will further enhance its strategic partnership with UNAIDS to fast-track the AIDS Response in Arab Countries and achieve the targets of the Arab AIDS Strategy".

Said Mr. Hatem Elrubi, Representative of the League of Arab States

Key Messages for UNAIDS Strategy

- **Sustainable and diversified mechanisms for** resource mobilization must support the ambitious goals for fast-tracking the response, with resources better targeted to key populations.
- The Strategy should build upon the **Arab AIDS Strategy**, including the commitments from all Ministers of Health, multisectorality and human rights-based approach of the Arab strategy.
- **Multisectoral programmes with multi-country partners** in the prevention of HIV among women and young people including sexual and reproductive health programmes with a focus on most affected, vulnerable and most-at-risk populations must be encouraged.
- **Rights-based approach**es **for key populations and the involvement of PLHIV** in designing prevention, testing, treatment and other interventions must be at the heart of the Strategy.
- Further investments are needed in **strategic information** generation to guide effective and efficient HIV responses.

Executive Summary and Consultation Methods

The UNAIDS Strategy consultation in MENA followed a bottom-up approach with national consultations in eight countries followed by one regional virtual consultation and a final regional consultation. All consultations involved government and inter-governmental counterparts, civil society networks and organizations, national, regional and global development partners, financing agencies and UNAIDS Cosponsors.

A common thread among all consultations was the need to keep AIDS on the regional agenda, particularly in light of political and humanitarian crises in the region. The Arab AIDS Strategy is a welcome and important contribution to the region's response; yet it is essential to ensure that it encourages action around scaling up the response in Arab countries and mobilizes regional political will and resources. Availability of resources for fast-tracking the response is a concern among the middle-, low-income and fragile countries alike.

The need to prioritize key populations and locations, especially cities and urban areas, based on strategic information was reiterated in all consultations. Addressing stigma and discrimination as well as integration and decentralization of the response were also seen as priorities in the region which must be reflected in UNAIDS Strategy.

Maintaining leadership for rights-based approaches, mobilizing and diversifying resources, integrating HIV services into primary and public health systems, strengthening the capacity and role of civil society in community responses and investing in South-South cooperation were identified as game changers in the region.

Consultation Questions: Discussion Summary

1. **HOW WILL DEVELOPMENTS – GLOBALLY AND IN THE REGION – IMPACT THE EPIDEMIC AND RESPONSE IN THE REGION, SUB-REGIONS AND SPECIFIC COUNTRIES OVER THE NEXT SIX YEARS?**

Political turmoil, conflict and security issues globally and regionally have driven significant mobility and migration in the region. As a result, social and health services have been disrupted, millions of people are vulnerable to violence, food and housing insecurity, human trafficking and other human rights violations – all with implications for the AIDS response. In these times of instability, the HIV agenda has been pushed down the priority list of national and international partners. Moreover, some countries are becoming a temporary or permanent destination for migrants from outside the region – putting added stress on health and other social systems.

The global partnership for development is also at stake. The emergence of the Ebola virus demonstrates the susceptibility of communities and countries and how global priorities can shift quickly.

The MENA region has one of the highest proportions of young people globally and it is forecasted that this will remain so in the coming six years. This 'youth bulge' can either provide a demographic yield that becomes the engine for growth and development in the region, or represent a risk to stability, if high unemployment and a collective sense of disenfranchisement grows. Further urbanization and the development of economic corridors within and between countries is expected, with implications for reinforcing, if not fuelling, inequality, and potential HIV epidemic hotspots.

The Arab AIDS Strategy has created a space in the region for bold national plans and inter-country accountability for fast-tracking the HIV response. With more countries recognizing HIV as a domestic priority, political commitment is on the rise. However, the lack of a stand-alone HIV goal in the post-2015 agenda may have implications for whether AIDS remains a national development priority, as well as holding countries accountable for AIDS commitments. Continued increases in global financing for the HIV response may be at risk, and it is likely that countries in the MENA region will be among the first to come off the donors' list.

New communication technology and social media have made interaction between people easier and out of the public eyes, particularly among young people. These tools can open doors for more participatory monitoring of the AIDS response across communities, and should be increasingly applied to the AIDS response.

The HIV response has benefitted from scientific advances, especially on treatment as prevention. However, we must ensure that ending AIDS as a public health threat does not become a commodity-driven strategy.

2. WHAT ACHIEVEMENTS OF THE REGIONAL RESPONSE SHOULD BE EXPANDED AND BUILT UPON? WHERE ARE THE MAIN CHALLENGES AND GAPS? WHO IS BEING LEFT BEHIND AND WHY?

Achievements
- Inter-governmental organizations like the League of Arab States and the African Union have mobilized country level political leadership. There are also non- HIV-specific laws and plans in place that can be used for the response, like labour laws and broader anti-discriminatory laws.
- Many countries are now producing strategic information and using them to inform their policies and programmes and have multisectoral national strategic plans focusing on their key priorities.
- Civil society organization and networks of PLHIV and key populations are becoming a strong partner in the national and regional response. Religious leaders are joining the movement.
- Peer educators and outreach workers provide partial or full packages of services and referral to key populations and PLHIV. HIV care and treatment are being provided free of charge. PMTCT programmes have started and are at scale in some countries. Some countries in the region have started integrating their HIV services into their public health systems and decentralizing them. Harm reduction and opioid substitution therapy are becoming more widespread in the region and policies are becoming more supportive of such services in some countries.

Challenges and gaps
- Punitive laws and policies are in place in many countries that fuel stigma and discrimination. While working to ensure more enabling legislative frameworks is essential, social and cultural norms that contribute to stigma and discrimination must also be addressed.
- Dependence on shrinking international funding for HIV response exists in most of the countries in the region.
- Strategic information is continually behind the epidemic - there is limited information available on incidence. The concentrated epidemics in the region and relatively low numbers of new infections per capita make investment in traditional surveillance tools somewhat inefficient.
- Considerable gaps in access to and utilization of services results in very low coverage of testing, ART and PMTCT. Public health services in many countries are generally centralized, underutilized, not integrated well into other health programmes and marred with frequent stock-outs, quality issues and stigma and discrimination by health care providers. Provision of provider-initiated counselling and treatment is very limited.
- While most of the projects and services delivered by civil society are stigma-free, the scope of their services and coverage area are limited. The full range of services needed to provide combination prevention and community testing or address gender norms are often not available.
- More tools and guidelines are needed in Arabic and other local languages.

Populations left behind in the region
- Sex workers, gay men and other MSM, people who inject drugs
- Intimate partners of key populations
- Prisoners
- Transgendered people
- Youth and women, especially young girls
- Some regions, sub-regions and cities are left behind by national responses

3. IN ORDER TO REACH THE FAST-TRACK TARGETS, WHAT SHOULD BE THE REGION'S STRATEGIC PRIORITIES IN THE RESPONSE?

The Arab AIDS Strategy provides a strong framework for fast-tracking the response and aligning with fast-track targets. Implementing the Strategy calls for engaging with high-level political leaders, working with parliamentarians to ratify the Arab Convention on Prevention of HIV and Protection of the Rights of PLHIV, removing punitive laws and legislations and targeting advocacy. It also provides a platform for multisectoral coordination, regional and national resource mobilization, South-South cooperation and strengthening networking across the region.

The potential to more closely engage with Arab philanthropic organizations should be realized – both in terms of resource mobilization and encouraging them to engage around stigma and discrimination reduction.

Mobilizing community and political leadership for addressing stigma and discrimination is a strategic priority for the region. Addressing human rights violations in a systematic approach and supporting CSOs and PLHIV networks to work independently of government influence and play their watchdog role alongside service delivery is an important step. Involvement of religious and media leaders is crucial.

Strengthening national and local M&E systems, mapping and generating strategic information in order to understand the trajectory of the epidemic, epidemic hotspots and gaps in the response is essential, as is investing in implementation research to improve effectiveness and efficiency of interventions. Real-time data should be a rule, rather than an exception.

The region needs to sharpen its focus on key populations and key locations, especially large cities and urban and economic hubs, and around key strategic goals. The approach to HIV testing and treatment must be transformed through community and private health care service delivery, more rigorous referral and linkage to services especially among key populations, simplifying ART regimens and integrating services into health sector.

It is essential to strengthen the health system, including the health workforce and investing in task shifting, and to strengthen the supply chain for ARVs and other commodities. Populations of humanitarian concern need to be included.

The HIV response needs to mainstream into health and other diseases and other development areas, diversify its resources and stress access to the most marginalized populations, working with youth and realizing their access to sexual education.

4. **WHAT WILL NEED TO CHANGE IN SUPPORT OF THOSE PRIORITIES? WHAT ARE THE "GAME-CHANGERS" – IN TERMS OF POLICY AND LAW REFORM, FUNDING, RESOURCE ALLOCATION, PARTNERSHIPS, SERVICE DELIVERY, EMPOWERING CIVIL SOCIETY, SCIENCE AND INNOVATION, AND LINKS WITH OTHER HEALTH AND DEVELOPMENT EFFORTS?**

High-level political leadership and engagement is the game changer for fast-tracking the HIV response in the region. The Arab AIDS Strategy and the League involvement at the regional level and political leaders at national and local level can ensure the response is addressed through high level policy. Engaging parliamentarians and ratification of the Convention can also change the landscape in law reform including around abolishing punitive laws and applying a broader and positive interpretation of existing laws and policies. CSOs need to be more involved in the process of ratification of the Arab Convention on the rights of people living with HIV (PLHIV).

A game-changer for funding in the region would be to increasingly diversify funding sources, going beyond the Global Fund, relying more on national resources through the creation of a special national fund where feasible. Low-income and fragile countries will remain dependent on external resources – in this case, a regional fund could be established. The funding can be also matched with technical South-South cooperation across the region. Responses must also become more efficient, including through multi-country purchase of commodities to decrease costs significantly.

In terms of partnership, the role of National AIDS Councils in coordination and mobilization should be strengthened, and partnerships with mega-corporations as well as faith-based organizations should be expanded, especially in humanitarian situations.

Civil society partners, including community and grassroots organizations, must be considered equal partners in the response and systematic efforts made to empower and define clear roles for PLHIV in designing, implementing and monitoring the response, in addition to delivering home-based care. Income-generating programmes for people living with and at heightened vulnerability to HIV can be game-changers in reducing vulnerability, and improving treatment adherence and overall health and well-being.

There is also a need for more effective combination ARVs, diversifying ARV baskets, and innovative drug delivery approaches.

5. **WHAT ARE THE MOST CRITICAL WAYS IN WHICH THE UNAIDS JOINT PROGRAMME CAN SUPPORT EFFORTS IN THE REGION TO END AIDS AS A PUBLIC HEALTH THREAT BY 2030?**

The UNAIDS Joint Programme can support the regional response in the following areas:

Political advocacy and mobilization
o   High-level political advocacy for HIV as a priority, integration of HIV into national development plans and promoting a right-based approach
o   Mobilizing all partners in the country
o   Better coordination of cosponsors, following QCPR
o   Building youth leadership

Resource mobilization, cost reduction and donor coordination
o   Mobilizing funds for low-income country responses, and for CSO programmes in middle income countries

o Advocacy for regional and national investment and country ownership
o Supporting countries access to low cost commodities

Technical support
o Technical support in design and implementation of national strategies
o Sharing best practices, new evidence and guidance
o Guiding the integration of AIDS

Strategic information
o Advising on strengthening collection of strategic information (accurate and up-to-date), in order to better monitor the epidemic and focus the response

Working with CSOs
o Capacity strengthening for CSOs, particularly around advocacy and communication, political and technical engagement, and service delivery

Partnership
o Facilitating South-South collaboration
o Supporting regional networks
o Promoting global research on drugs and vaccines
o Engaging politicians, parliamentarians and religious leaders in the response

GENERAL REFLECTIONS

- Despite progress in the response, there is no room for complacency. HIV has to remain a priority for Cosponsors and government sectors beyond Ministries of Health.
- The MENA region is experiencing an unstable socio-political situation, which could negatively affect the regional response and increase vulnerabilities.
- The purchase price of ARVs and reagents are high. UNAIDS should strengthen its role in supporting countries to negotiate price reductions and explore innovative purchasing strategies (group purchasing, etc.).
- Urban-specific responses need to be defined and implemented.
- The leadership, priorities and specific vulnerability of young people must remain at the centre of the AIDS response.

MIDDLE EAST AND NORTH AFRICA: PARTICIPANT LIST

Algeria	Morocco	Sudan
Comité National de Prévention et de le Lutte Contre le Sida : Expert Comité National de Prévention et de le Lutte Contre le Sida : Laboratoire national de référence Comité National de Prévention et de le Lutte Contre le Sida : Ministère des Affaires Religieuses Comité National de Prévention et de le Lutte Contre le Sida (CSO) UNICEF UNFPA WHO	NAP Global Fund Directorate of Diseases Control National Program on Drug Use Regional Health Directorate/Fez Population Directorate/MoH ALCS (NGO) OPALS (NGO) LMLMST (NGO) LMLMST (NGO) CMP Hasnouna (NGO) AMPF (NGO) AMSED (NGO) Ministry of Youth and Sports Police Department Prison Department National Council on Human Rights UN Women WHO	UNAMID IOM UNFPA UNICEF UNHCR UN Women UNDP Global Health Foundation WHO Sudan National AIDS Program CAFA Sudanese Association for Community Development Ministry of Social Welfare Sudan AIDS Network

Egypt	Iran	Tunisia
Director of Ministry Of Health Technical Office National AIDS Programme Alexandria Regional Center for Women's Health Shehab NGO Ryada NGO Freedom NGO FHI 360 Egyptian Family Planning Association Caritas/ENNAA Director of Ministry Of Health Technical Office National AIDS Programme Alexandria Regional Center for Women's Health Shehab NGO Ryada NGO Freedom NGO FHI 360 Egyptian Family Planning Association Caritas/ENNAA Egyptian Medical Women Association	Iranian Red Crescent Society MoH - International Affairs Dept MoH - Family Health Dept MoH - Center for Communicable Disease Control MoH - Psycho-social Health and addiction Dept MoH - Health Economy and Budget Dept MoH - Health Promotion Dept Universities of Medical Sciences and academia Various Non-Governmental Organisations including Red Ribbon Award winner Ministry of Cooperatives, Labour and Social Welfare Ministry of Sports and Youth UNDP UNICEF UNODC	Ministère des Affaires Sociales Experte nationale Représentant de l'OMS Chargé pays ONUSIDA Secteur des Religieux Chef de Service d'Infectiologie/centre de prise en charge Rabta Key population Association MANARA de réduction des risques Représentant association de PVVIH Association de la Jeunesse Scolaire Association des Jeunes Médecins sans Frontières Le Croissant Rouge Tunisien Association Tunisienne de Lutte contre les MST et Sida de Tunis Association Tunisienne d'Information et Orientation sur le Sida et la Toxicomanie Association Tunisienne des Sages-Femmes Ministère des Affaires Sociales

(EMWA) Egyptian AIDS Society IFMSA Egypt International Consultant - NSP Professor of Public Health / NAP HIV Adviser Professor of Public Health Ain Shams University UNICEF IDLO	UNFPA WHO Drug Control HQ Blood Transfusion Organization I.R. Iran Broadcasting (national TV and radio) Representatives of PLHIV, vulnerable women and IDUs Ministry of Education Ministry of Foreign Affairs Kerman HIV knowledge Hub Ministry of Transport Prison Organization Iranian Research Center for HIV and AIDS Ministry of Interior Imam Khomeini Relief Fund Iranians Health Insurance Organization	Ministère de la Jeunesse, des Sports, de la Femme et de la Famille Association Tunisienne de Prévention de la Toxicomanie Chef de service d'infectiologie /centre de prise en charge Monastir Directeur de la santé, Direction Générale des prisons au ministère de la Justice Direction des Soins de Santé de Base au Ministère de la Santé Direction des services de santé au ministère de l'Intérieur Coordinatrice du Programme National de Lutte contre le Sida / DSSB ministère de la Santé. Directeur Exécutif du CCM et ex- coordinateur PNLS
Mena WebX Coordinator, MENAHRA MENARosa Focal Point Egypt Focal Point, MENANPUD Project Coordinator, SIDC Focal Point, CHAHAMA ITPC, Morocco Youth Leader and member of RLs Rabeta Oulama in Morocco NAHR Netowrk, Egypt PLHIV & MSM representaive, Egypt M Coalition AFEMENA	**MENA Regional** All Cosponsors represented League of Arab States Executive Director, MENAHRA Executive Director, RANAA Regional Coordinator, MENARosa Associate Director for Africa International AIDS Alliance IDLO Director, Drossos FHI SCORA - Youth Representative Regional Arab Scout Organization Middle East and North Africa Health Policy Forum Global Fund Ford Foundation	

Discussion Note
Consultation on the UNAIDS 2016-2021 Strategy:

WASHINGTON DC

13 March 2015, Washington, D.C., USA

KEY MESSAGES FOR UNAIDS STRATEGY

- Investment in **organizations and networks led by people living with HIV** must be scaled up. Social change and local commitment has always come through their leadership and mobilization.
- **Investment cases that drive domestic resourcing** of the response are critical to sustaining and leveraging U.S. commitment.
- **Criminalization and other punitive laws** and policies need continued attention as they increase vulnerability and stand in the way of HIV services. In many places, HIV is one of the few issues that enables political leverage and sway with officials on these sensitive subjects.
- U.S. partners view UNAIDS' **strategic information, political leadership and inclusion of civil society in governance and programme design** as its greatest strengths. These are areas where we can build on success to address emerging needs and challenges in the global response to the HIV epidemic, towards the goal of ending AIDS as a public health threat by 2030.

EXECUTIVE SUMMARY

The UNAIDS Strategy consultation with U.S. civil society and other partners took place on 13 March, hosted by the Global AIDS Policy Partnership (GAPP), with additional participation from U.S. domestic groups. It was a fruitful discussion focused on three questions:

- What are the game-changers for the response – towards ending AIDS as a public health threat by 2030 and leaving no one behind? (global and domestic)
- What will it take to sustain U.S. commitment and fully leverage U.S. investments?
- Where do you see UNAIDS' comparative advantages in helping to drive this agenda?

Both the GAPP and the Federal AIDS Policy Partnership (FAPP) circulated the notice of the consultation on their listservs, and advertised to other groups as well. Membership in the GAPP and the FAPP covers many of the major civil society and implementation groups in the U.S. working on HIV (global and domestic focus). The UNAIDS strategy background paper was circulated to the full GAPP and FAPP memberships in advance of the consultation. About 20 organizations participated (in person and dial-in, some with more than one representative).

CONSULTATION QUESTIONS: DISCUSSION SUMMARY

1. HOW WILL GLOBAL AND NATIONAL DEVELOPMENTS – POLITICAL, ECONOMIC, SOCIAL, TECHNOLOGICAL – IMPACT THE HIV EPIDEMIC AND RESPONSE OVER THE NEXT SIX YEARS?

Participants agreed that the discussion paper presented a very useful and succinct summary of where we are with the epidemic and the response to date, as well as emerging developments that need to be taken into account for the future.

Generating sufficient investment in ending AIDS is a prerequisite for success. Because of the success of the AIDS response in generating resources in the past 15 years, there was concern expressed about the perceived counter-reaction of some governments – pulling out resources and redeploying to other issues, even in the face of economic growth. Investments in HIV and health should be additive and catalytic, rather than "crowding out resources". Strong investment cases – showing why funds should go into HIV, among all the various needs and priorities – will be critical strategic tools for UNAIDS and boost the efforts of in-country advocates. It was noted that the "15% for health" Abuja target has only been modestly successful in mobilizing resources from national governments. UNAIDS was asked to help the world think of and commit to other ways of generating resources (e.g. domestic tax collection to fund the end of AIDS) and ensure that resources match the ambitions and opportunities before us.

Participants expressed concern that the voice of people living with HIV has become muted in recent years. There is urgent need to invest in their leadership. It was emphasized that change and local commitment has always come through the leadership and mobilization of positive people. It was also noted that there is a generation of people over 50 living with HIV who remember the fierce presence and advocacy of groups like ACT-UP. Many are in the U.S., but there are others in Western Europe and Australia. This is another group that should be supported to rise up, reignite their passion, and be part of ending AIDS as a public health threat.

2. WHAT ACHIEVEMENTS OF THE RESPONSE TO DATE SHOULD BE EXPANDED AND BUILT UPON? WHERE ARE THE MAIN CHALLENGES AND GAPS? IN PARTICULAR, HOW DO WE BETTER ADDRESS THE SITUATION OF THOSE BEING LEFT BEHIND?

The most important successes to date have been the ability to mobilize political commitment, community engagement and resources, as well as generate sound data as a tool of accountability and to inform programming. All these efforts need to be sustained and expanded.

Continued work is needed to reach key populations and ensure there is political will to do so. This is increasingly important in the face of a growing focus on domestic investment and signs that programmes for key populations are suffering when donors withdraw from middle-income countries. Criminalization and other punitive laws and policies need continued attention as they increase vulnerability and stand in the way of HIV services. In many places, HIV is one of the few issues that provides opportunity to open discussion on these sensitive subjects.

The challenge of TB/HIV co-infection has not seen the progress that was hoped for at the outset of the current UNAIDS strategy. With increasing HIV treatment numbers, one would have expected a larger reduction in TB mortality among people living with HIV who are

accessing antiretroviral therapy. Increasing access to treatment for other co-infections, notably Hepatitis C, is an opportunity, but it will require a focus on bringing costs down.

The place of children in Fast-Track needs to be elevated as they are not sufficiently visible in the targets and data. In addition to continuing to highlight gaps in treatment access, it was recommended that discrimination in the education sector be included in UNAIDS targets as this is where children encounter it most, and it can be a factor in children going off treatment (or not getting to it in the first place).

Faith communities have the potential to be a force to reach people left behind in a world with inequality, conflict, forced migration, increasing refugee crises, and rape as a weapon of war. The only way to respond to such challenges is with a social force that can educate, provide protection and care, and with regards to HIV, show that it is okay to get tested and go on treatment.

3. WHAT IS THE ROLE OF U.S. PARTNERS IN REACHING THE FAST-TRACK TARGETS – GLOBALLY AND DOMESTICALLY?

It was noted that there is an increasing need and opportunity to link the domestic and global conversations in the U.S. The 90-90-90 treatment targets have been very helpful for generating a new conversation in relation to the domestic agenda. Progress in the U.S. response has stagnated (e.g. roughly 50,000 new infections each year for years on end), attributable to a range of factors. With the 90-90-90 agenda, public officials can clearly see that the U.S. is nowhere near 90, and there is appetite to discuss how to better prioritize and get the best response from the investments being made.

The support of top political leadership is always critical. It was noted by participants that now is the moment for U.S. civil society to engage all presidential candidates – across party lines – and encourage them on HIV. Without this, HIV risks being off the table when the U.S. still has much to contribute to reaching the goal of ending AIDS.

4. WHAT WILL NEED TO CHANGE IN ORDER TO ACCELERATE PROGRESS? WHAT ARE THE "GAME-CHANGERS" – IN TERMS OF FUNDING AND RESOURCE ALLOCATION, SCIENCE AND INNOVATION, EMPOWERING CIVIL SOCIETY, SERVICE DELIVERY, SUPPORTING POLICY AND LAW REFORM, AND PARTNERSHIPS WITH SOCIAL MOVEMENTS AND THE PRIVATE SECTOR?

Participants identified a number of actions, approaches and constituencies that are critical to accelerating progress and ending AIDS as a public health threat by 2030:

- Investing in people living with HIV – change and local commitment has always come through their leadership and mobilization.
- Going back into "emergency mode" – that is what Fast-Track implies. Without urgent action, more than 20 million people face death without access to treatment. In particular, intensified efforts are required to close the paediatric treatment gap.
- Resources – new groups coming into the response are told to ramp up with less resources; it is incredibly difficult. How can UNAIDS help the world tap into innovative financing?
- Faith communities – increase engagement and through them reach congregations, communities; harness the potential for inclusion and education, increasing uptake of testing, treatment and support.

- Active UNAIDS role in the CCMs – a collective effort is needed to strengthen this important mechanism.
- Ending drug-resistant TB – there are plausible scenarios of a rapid increase in transmission that consumes billions of dollars of resources that should otherwise go to securing broader health gains.
- mHealth – new technologies should not only improve data, but also help us reach those who are not currently reached.
- Controlling drug costs – have to get prices down for second, third-line HIV treatment, as well as medicines for co-infections (notably Hepatitis C).
- Ending stigma, discrimination and criminalization.
- Data/scorecards for accountability – these help advocates push for progress. Need to expand – for example, to see the percentage of domestic resources invested in HIV, and legal and policy barriers. (The focus on travel restrictions has been great, but need a few more.)

In addition, it was acknowledged that vaccine and cure research has the potential to lead to a scientific game-changer. These efforts need the political advocacy and support of UNAIDS.

For UNAIDS to maximize its impact, it was noted that there needs to be greater coherence and focus vis-à-vis its internal workings across the co-sponsors, as well as with the Global Fund. Too often there is role confusion, as well as signs that the Global Fund's mission is expanding to take on a policy function that is beyond its mandate and potentially at odds with UNAIDS' leadership and standards role.

5. WHAT ARE THE MOST CRITICAL WAYS IN WHICH THE UNAIDS JOINT PROGRAM CAN CATALYZE AND SUPPORT EFFORTS TO END AIDS AS A PUBLIC HEALTH THREAT BY 2030?

Participants generally spoke about three areas where UNAIDS has strong comparative advantage, and suggested ways of evolving our approaches to increase their impact and ensure their continued relevance:

- Data – UNAIDS is good at breaking down the data in ways that show us who is left behind, steering us to the actions to reach them. Going forward, we need to disaggregate in new ways, for example to see the situation of the urban poor (not just "urban vs rural"), and smaller age brackets for children (the situation of 0-5 years is much different than 10-15 years).
- Political leadership – UNAIDS is one of the few organizations capable of pushing governments and generating political will, using data and standards to hold countries accountable (particularly in the face of difficult issues, like key populations and criminalization/marginalization, and competing priorities, like non-communicable diseases).
- Engaging people living with HIV and amplifying the voices of activists; accompany/support the rising groups in countries, and hold itself accountable for advocacy success at local level.

Going forward, it will be important that data, political advocacy and social mobilization reach the local level. The cities approach will be useful in this regard. It was noted that major inroads are needed against stigma and discrimination, which has proven stubborn and persistent around the world.

UNAIDS can help the world understand that protecting and promoting public health takes more than just clinical medicine. Too many people still think this is a challenge of doctors, clinics and pills, and do not fully understand that success requires tapping into the community level. The science, evidence and experience is there. UNAIDS can use its institutional assets to communicate what the response looks like and where the resources need to go to get the job done.

Additional issues raised during the consultation process

One of the questions raised by participants was, "Is UNAIDS losing the 'universal access' message by talking about targeting high-transmission settings?" It will be important to keep this perception in strategic directions and key messages are developed so that people see how efforts to focus on location and population are the pathway that gets the response to "no one left behind".

WASHINGTON DC: LIST OF PARTICIPANTS

1. amfAR
2. AIDS Alliance
3. AVAC
4. Children's AIDS Fund International
5. Communities Advocating Emergency AIDS Relief (CAEAR) Coalition/New York City Department of Health
6. Elizabeth Glaser Pediatric AIDS Foundation
7. Friends of the Global Fight against AIDS, TB and Malaria
8. Futures Group
9. GNP+
10. Institute for Youth Development
11. International AIDS Empowerment
12. International AIDS Vaccine Initiative
13. International HIV/AIDS Alliance
14. John Snow, Inc.
15. National Association of Social Workers
16. ONE Campaign
17. Ribbon Consulting Group
18. Save the Children USA
19. Urban Coalition for HIV/AIDS Prevention Services

Discussion Note
Regional Consultation on UNAIDS Strategy 2016-2021:

CARIBBEAN

16 March, 2015 - Kingston, Jamaica

"We too often start with global priorities and what donors want. If we think of national priorities and strategies we can build more meaningful movements and get better results."
Jaevion Nelson, Caribbean Vulnerable Communities

KEY MESSAGES ON UNAIDS STRATEGY

- **Community empowerment and involvement are critical**. In order to address stigma and discrimination, communities must be empowered to become more involved in responses and advocacy.
- **There must be a "laser focus" on who is being left behind**. This requires targeted research and responses, as well as the inclusion of groups that may not be consistently listed among "key populations" by international partners, such as young people, adolescent girls, homeless children and orphans.
- **Strategic advocacy is required to change discriminatory and punitive laws** in the Caribbean. This process will likely have more than a six year arc for some of the more entrenched statutes such as those on homosexuality and sex work. Other laws relating, for example, to travel restrictions or child marriage, can be successfully amended in a shorter timeframe.
- The **financial sustainability of Caribbean HIV responses** is an urgent and fundamental concern and plans are needed to support the transition to increased and diversified domestic investments. It requires a combination of increased national efficiency, regional advocacy, engagement of the private sector and international partnerships.
- There is a **need to integrate HIV treatment into other branches of the primary healthcare** system to reduce both the stigma and discrimination and the inefficiencies associated with stand-alone HIV services. Health systems, including laboratory services, must be strengthened.
- **Gender-responsive approaches are needed**. These will strengthen prevention, testing, treatment and care interventions to ensure that no group—including men and transgender people—is left behind.
- The **Pan Caribbean Partnership against HIV and AIDS** (PANCAP) must be strengthened. PANCAP should re-strategise in order to better help Caribbean countries meet challenges surrounding policy-development, legal reform and social change.
- **HIV must find a strategic space among new global Sustainable Development Goals** and strategically align with key issues relating to health, human rights and gender.

CONSULTATION METHODS

HIV programme managers, clinicians, academics, civil society advocates, government officials and development partners from 12 Caribbean countries were invited to participate based on their thematic and technical strengths and following consultations with UNAIDS country offices. The NGO Delegate to the PCB for Latin America and the Caribbean participated. Among the cosponsors represented at the consultation were UNDP, PAHO, UNICEF and UN Women. All participants were provided with the five consultation questions and agenda before the full day meeting. Questions 1 and 2 were discussed in plenary.

Questions 3, 4 and 5 were contemplated by three breakout groups. Each group reported on its main recommendations. The meeting concluded with summary conclusions and reflections on the way forward. The final discussion note was shared with participants prior to finalisation.

FIVE CONSULTATION QUESTIONS: DISCUSSION SUMMARY

1. **HOW WILL DEVELOPMENTS – GLOBALLY AND IN THE REGION – IMPACT THE EPIDEMIC AND RESPONSE IN THE REGION, SUB-REGIONS AND SPECIFIC COUNTRIES OVER THE NEXT SIX YEARS?**

- **New language and strategies are needed to address issues of rights, inequity and gender**. With the idea of "Human Rights" in the Caribbean widely interpreted to be an internationally-driven "gay" agenda, HIV stakeholders will have to strategise to alter this perception as they work to influence people and policy-makers.
- **Financial constraints necessitate doing more with less, being more efficient and rethinking HIV funding**. Regional and global financial realties including low or no economic growth, high national debt burdens and lowering international investments in HIV are likely to impact access to treatment. This will affect the agendas of AIDS programmes and civil society while placing new emphasis on the role of the private sector. While all Caribbean Small Island Developing States contend with a degree of economic vulnerability and challenges to accessing funding, the issue is particularly critical for Antigua and Barbuda, the Dominican Republic, Guyana, Haiti and Jamaica.
- **Litigation around human rights and civil liberty issues related to key populations will present new challenges and opportunities.** Judicial challenges to punitive/discriminatory laws (currently affecting Belize, Guyana, Jamaica and Trinidad and Tobago) will likely further mobilise conservative forces. They will also create opportunities for national and regional dialogues.
- **Strategies are required to engage religious groups and address their influence on Governments and communities.** Some faith-based organisations, and particularly conservative Christian groups, may continue to be influenced and funded by global religious right movements as they advocate against legislative, policy and programmatic changes in support of a more inclusive AIDS response.
- **The link between abuse and HIV must be addressed.** Violence, including intimate partner violence and child physical and sexual abuse, increases HIV vulnerability and requires cross-cutting policy and programmatic measures.
- **The movement of Caribbean people has implications for HIV prevention, treatment and care.** As economic forces intensify already dynamic migration patterns throughout the region, there will be continued implications for treatment and care access for PLHIV, prevention services for sex workers and their clients and human rights protection for illegal immigrants.
- **Regional bodies' roles in shaping the Caribbean HIV response must be strengthened.** The organisation and performance of regional coordination mechanisms (e.g. PANCAP and CARICOM) will impact what will be prioritised and achievable in the future. The PANCAP model needs to be revised to ensure that it can help the region meet its challenges surrounding policy-development, legal reform and social change.
- **HIV must complement, rather than compete with, new health priorities.** The non-communicable disease agenda is a priority for Caribbean governments. Therefore, stakeholders must leverage the lessons of the HIV response and, where possible, attract joint HIV-NCD investments.
- **HIV must find a strategic space among new global Sustainable Development Goals**. As these goals will shape funding and programmatic priorities for governments,

HIV stakeholders will have to strategically align with key issues relating to health, human rights and gender to ensure that HIV is not de-prioritised in the post-2015 era.

- **The success of several Caribbean countries in eliminating new HIV infections among children** is attributed to strong antenatal healthcare programmes that have integrated HIV prevention and treatment. There is a need to integrate HIV treatment into other branches of the primary healthcare system. In order to achieve this, health systems, including laboratory services, must be strengthened. In part, this requires greater allocation of national GDPs to the healthcare sector.
- Modes of Transmission and other studies point to **successes in drastically lowering HIV transmission rates among female sex workers** in some countries. This is attributed to consistent, quality peer education approaches. However, little work has been done to understand and address the needs of male and transgender sex workers as well as transactional sex and sex work among young people.

"I think we have an immense problem with our transgender community. They are thrown out and treated as pariahs. Social marginalisation takes place in schools and communities. The message is clear: you are different and not wanted. We push them to the margins. If there are no social programs to address this in communities and schools, you're not going to solve that problem."

John Waters, Centro de Orientación e Investigación Integral

- Although new infections have declined by 50% since 2001, **a lack of evidence-based and target audience-specific approaches to prevention persists in many countries.**
- Starting from the pre-service level, **the training of healthcare personnel in the region must be restructured to focus on the future response to HIV and health**, especially in the context of sustainable development.
- There has been extensive, inter-disciplinary research on various issues impacting the HIV response; however, **opportunities remain for research analysis and synchronisation with National Strategic Plans**. Additionally, more qualitative research is needed to examine personal and environmental issues such as social inequity, family and peer groups as it relates to various key populations. The research agenda should establish baselines as well as identify drivers and entry points.
- There has been an **increase in attempts to measure stigma among PLHIV, healthcare workers and general populations.** This needs to be developed into a unified approach to tracking and addressing stigma, including self-stigma.
- **Populations are still being left behind**. Overall there has been inadequate attention to social protection, gendered approaches to HIV interventions and the involvement of key populations.

"Girls have three to four times the HIV infection rate of boys from ages 14 to 19. You have teens getting pregnant twice and more times within that period. They are subject to predators. It is a human rights issue. I am not hearing about the rights of children to protection."

Shiela Samiel, UN Women

- **Young people and orphans** are not meaningfully targeted through most national responses. Although the data emphasises the particular vulnerability of adolescent girls (e.g. HIV prevalence, pregnancy, rape etc.), there is little programmatic and donor emphasis on this group.
- **High risk heterosexual men** are often excluded. An additional focus on men's health may help to capture both this group and MSM and lead to more effective prevention outcomes.
- There are inadequate interventions and research to address the epidemic among **transgender** people.

- There is evidence of a growing HIV prevalence among **crack cocaine users and deportees** with injecting drug habits.
- The **needs of people who were either born with HIV or are aging** with the virus are inadequately understood and met.
- **Key populations and communities** are not sufficiently engaged and empowered to be part of the response.

2. IN ORDER TO REACH THE FAST-TRACK TARGETS, WHAT SHOULD THE REGION'S STRATEGIC PRIORITIES IN THE RESPONSE BE?

"As a region of small islands we are best positioned of all regions in the world to accomplish these treatment goals because of our size and infrastructure. We can do it."
Merceline Dahl-Regis, Former Chief Medical Officer, The Bahamas

- **Securing high level political commitment** so that HIV remains a development priority that attracts appropriate budgetary allocations. This is also critical to achieving the health system strengthening and universal health coverage on which the AIDS response depends.
- **Addressing stigma and discrimination and human rights challenges** at the policy, legislative and social levels. Building an enabling environment that supports testing and treatment access as well as adherence.
- Countries should have a **national financial sustainability plans** to support the transition to increased and diversified domestic investments. At the same time, governments should jointly seek new avenues to negotiate lower treatment prices.
- Steps should be taken to **address demand and supply for testing in order to increase early detection**. This should include public education, the review of Voluntary Counselling and Testing protocols and the scale-up of community services.
- **Strengthen reporting linkages between the private and public healthcare sectors** to ensure that all population segments are being captured in the data.
- **Expand treatment, care and support services.** Once demand is created for early treatment, emphasis must be placed on supporting adherence through the retraining of health care workers and increased emphasis on peer to peer interventions as well as family support.
- **Build gender-responsive approaches** to prevention, testing, treatment and care interventions to ensure that no group is left behind.
- **Strengthen data collection**. Include mapping and monitoring of prevention interventions and the development of cascades that are both country and community-specific.

3. WHAT WILL NEED TO CHANGE IN SUPPORT OF THOSE PRIORITIES? WHAT ARE THE "GAME-CHANGERS" – IN TERMS OF POLICY AND LAW REFORM, FUNDING, RESOURCE ALLOCATION, PARTNERSHIPS, SERVICE DELIVERY, EMPOWERING CIVIL SOCIETY, SCIENCE AND INNOVATION, AND LINKS WITH OTHER HEALTH AND DEVELOPMENT EFFORTS?

- **Partnerships with influentials.** Building relationships with political power-brokers in and out of government.
- **Full civil society engagement.** Outreach and meaningful partnership with civil society, including capacity-building in relation to testing and psycho-social support.
- **Strengthening and partnering with communities.** Community system strengthening and partnerships with non-health sector stakeholders.
- **Better data, analysis and application.** Improved quality data and analysis for programmatic decision-making, including cascade data for key populations.

- Improved protocols and implementation surrounding **confidentiality, testing and treatment access as well as adherence support** to address stigma and discrimination in healthcare settings.
- **Investing in and monitoring peer-to-peer approaches** for community support and gender-responsive programming.
- **Evidence-informed shift** toward targeted prevention, treatment, care and adherence messaging for key populations and other target audiences.
- **Comprehensive sex education and sexual and reproductive healthcare access for young people.** This requires a combination of policy/law reform to address access issues, evidence-based revisions of curricula and stakeholder engagement to ensure quality implementation.
- **Engagement with and buy-in from the faith-based community** in support of prevention, treatment care and social justice goals.
- **Private sector engagement** to ensure a clear understanding of the HIV issues, their social and economic implications and the best opportunities for investment.
- **Integrated services** to reduce both the stigma and discrimination and the inefficiencies associated with stand-alone HIV services.
- **Dedicated funding for monitoring and evaluation** to ensure that only quality interventions continue and attract investments.

4. WHAT ARE THE MOST CRITICAL WAYS IN WHICH THE UNAIDS JOINT PROGRAMME CAN SUPPORT EFFORTS IN THE REGION TO END AIDS AS A PUBLIC HEALTH THREAT BY 2030?

"We have to think through ways to engage, but we also need to also restructure the way we communicate about HIV in the Caribbean. When we start talking about 'human rights' it is something they don't understand. What can we do to make it feasible to have that discussion?"

Carlo Oliveras, International Treatment Preparedness Coalition

- Don't "Fast Track" in a carte blanche manner. Support deliberate, focused action or support national responses in re-focusing efforts and resources where necessary.
- Collaborate with government, civil society, academic and other stakeholders on medium-term strategies for securing both political commitment for HIV as well as reforms to support the AIDS response.
- Lead and support advocacy to position HIV along with the NCD and social justice agendas. Contextualise HIV among issues including health system strengthening and social inequity. Bring other stakeholders to the table.
- Offer technical support to critical regional stakeholders. Specifically, assist PANCAP in strengthening its programme coordination, legislative reform and procurement functions.
- Ensure consistent focus on the development and evaluation of evidence-informed and effective approaches for national and regional prevention.
- Prioritise the strengthening and inclusion of civil society to bolster service-delivery and advocacy efforts. In some respects this would involve regaining the trust of civil society organisations.
- Technical support for the generation of improved strategic information including granular data and cascades for each country. Data should be disaggregated from a Latin America and the Caribbean (LAC) total to fully evaluate progress. They should also point to which people in which places are particularly vulnerable.
- Facilitate South-South cooperation so that the Caribbean can access lower priced antiretroviral drugs.
- Continue supporting countries through high-level engagement to address the sustainability of HIV programmes and technical support to finalise and implement financial sustainability/investment plans.

GENERAL REFLECTIONS

- UNAIDS slogans and initiatives need to translate into manageable expectations. For example, the capacities and health/HIV budgets of several Caribbean countries are not currently able to cope with the 90-90-90 targets.
- Funders' priorities may not always respond adequately to national epidemiological and social needs.

CARIBBEAN: LIST OF PARTICIPANTS

Edward Greene	UN Special Envoy for HIV/AIDS for the Caribbean
Maria Pereira	Clinician
Christine Barrow	Consultant
John Waters	Centro de Orientación e Investigación Integral
Richie Maitland	Groundation Grenada
Sarah Insanally	The Pan Caribbean Partnership against HIV and AIDS
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Ermane Robin	Haiti Ministry of Health
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Jeffrey Barrow	Clinician
Sannia Sutherland	Jamaica Ministry of Health
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Peter Figueroa	The University of the West Indies, Mona
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Ainsley Reid	PCB, Caribbean Regional Network of people Living with HIV/AIDS
Colin Bullock	Planning Institute of Jamaica
Dennis Chung	Private Sector Organisation of Jamaica
Nicola Skyers	Jamaica Ministry of Health
Carlo Oliveras	International Treatment Preparedness Coalition
Lillian Pedrosa	The Global Fund to Fight AIDS, Tuberculosis and Malaria.
Severine Calza	The Global Fund to Fight AIDS, Tuberculosis and Malaria.
Merceline Dahl-Regis	Consultant; former Chief Medical Officer of the Bahamas
Roger McClean	The University of the West Indies, St. Augustine
Colin Robinson	Caribbean Forum for Liberation and Acceptance of Genders and Sexualities
Verna St Rose-Greaves	Social worker; former Minister of Gender Youth and Child Development of Trinidad and Tobago
Jennifer Knight-Johnson	President's Emergency Plan for AIDS Relief
Deborah Henningham	President's Emergency Plan for AIDS Relief
Mylene Pocorni	Suriname Country Coordinating Mechanism

Cosponsors	
Karin Santi	United Nations Development Programme
Sheila Samiel	UN Women
Kam Suan Mung	Pan American Health Organisation
Marvin Gunter	United Nations Population Fund
Arun Kashyap	United Nations Development Programme
Mark Connolly	United Nations Children's Fund

Discussion Note
Consultation on the UNAIDS 2016-2021 Strategy:

NEW YORK

18 March 2015, 9:00-14:00, UN Foundation, New York City

KEY MESSAGES FOR UNAIDS STRATEGY

This Strategy can be effective and we can end the AIDS epidemic *only if* we:

- Tackle front and centre issues of **sexual rights, decriminalization, gender equality and human rights** including through supporting changes to legal environments. Strong leadership from UNAIDS on these issues including through political advocacy in intergovernmental processes will be critical.
- **Address the social determinants and drivers of the epidemic** through structural interventions including housing, employment, food security measures, social protection and ensuring care and support, which have a critical role in improving adherence rates, achieving viral suppression and generating co-benefits for AIDS and other SDGs.
- **Implement integration on multiple levels** – advocacy, policy, financing, service delivery and reaching out to other communities beyond traditional HIV and health actors.
- **Adequately invest in activists and civil society** to effectively do their work.
- **Reset the Joint Programme's relationship with civil society**. Participants flagged that UNAIDS' partnerships with civil society could be improved. This must be addressed by UNAIDS and should be discussed with civil society partners.
- **Go beyond treatment.** Prevention, care and support are critical and must not be sidelined. Human rights are the prophylaxis and structural interventions are the cure.
- **Be realistic about levels of funding attainable** and ensure that funding is invested strategically to benefit the most vulnerable first and that these populations are not the first to get dropped in fiscal crunches.
- **Track adherence and viral load suppression** not just the number of people on treatment.

EXECUTIVE SUMMARY

Around 20 New York-based stakeholders from civil society, academia, think tanks and the private sector came together with UNAIDS Secretariat and Cosponsor staff to discuss the UNAIDS 2016-2021 Strategy in a 5-hour conversation structured around six major themes. Given the global perspective of many New York-based stakeholders and the deep involvement of many in the post-2015 development agenda process, the first session of the consultation focused on the intersection of the UNAIDS Strategy and the post-2015 development agenda. Participants considered what transformation could look like in the AIDS response and the game changers to get there, as well as the implications of a universal post-2015 agenda for the UNAIDS Strategy. The second session discussed current and future trends and their implications for the AIDS response, while the third session examined successes and gaps in the response – globally, in the US and in New York City. Sessions four and five focused on financing and access to services and medicines (including the role of innovation, R&D and new technologies), respectively and session six wrapped up with the role of UNAIDS in implementing the Strategy and ending the AIDS epidemic by 2030.

Participants were eager that the Strategy should not be considered by UNAIDS only as an exercise to 'please the Board and donors'. They cautioned that this might do no harm but such an approach would equally do no good. Participants wished to see a Strategy that:

- Is a short, readable document that provides concrete recommendations including specific examples and language of what policy and legal changes could look like and practical ways to achieve feasible and well-financed responses.
- Encourages continued investment in and scale up of resources for AIDS – in this sense an 'advertising' document.
- Articulates UNAIDS' leadership role and how UNAIDS and Member States can be held accountable for their commitments.
- Outlines what success looks like each year until 2021 in terms of how UNAIDS wants to be performing and working with partners – donors, the UN family, civil society and others so that stakeholders understand the Strategy in relation to them and their role in implementation.
- Demonstrates the relationship between and brings together in a coherent package the UNAIDS vision and policy advice on 90-90-90 and other strands.

METHODS

A broad range of relevant stakeholders living in New York and nearby working on HIV and AIDS, global health and development were invited to attend this consultation. Cosponsors based in New York (UNFPA, UNICEF, UNDP and UN Women) were invited to attend as was WHO. Both North American delegates for the NGO delegation to the UNAIDS Board were invited to attend. One (Charles King) participated and the second (Laurel Sprague) reviewed the participants list and requested that additional representatives (for example from the US PLHIV Caucus) were invited who subsequently participated. Members of the UNAIDS Reference Group on HIV and Human Rights living in New York were also invited to attend and two were available to participate. A draft report of the consultation was shared with participants for comment within one week of the consultation. Minor comments were received from one participant and incorporated in the subsequent draft.

CONSULTATION QUESTIONS: DISCUSSION SUMMARY

1. **WHAT TRENDS – GLOBALLY, NATIONALLY, LOCALLY – WILL IMPACT THE MULTIPLE AIDS EPIDEMICS AND RESPONSES IN THE COMING SIX YEARS AND HOW CAN THIS STRATEGY ENSURE IT IS ABLE TO ADAPT TO NEW REALITIES WHILE REMAINING EFFECTIVE?**

- There is a worrying trend of growing conservatism to human rights in many parts of the world with new punitive laws being put in place. This was demonstrated at the 59th Commission on the Status of Women (CSW59) where the most contentious issues among Member States were related to gender equalityand civil society participation.
- The space for civil society to participate both at the country level and in intergovernmental processes is narrowing. This is part of a broader attack on civil society – the open attack on the Treatment Action Campaign in South Africa is one example.
- More and more, people are representing themselves instead of seeing nation states as the dominant power and primary governance structure. This can be seen through horizontal networks across national boundaries challenging traditional vertical power between states and citizens.
- Inequality and inequity are increasing all over the world, both between and within countries. A greater push on equity is needed.

- Mobile technologies and social media are being used increasingly all over the world. This is particularly the case among young people and it has major implications for the Strategy including how technology increases the easy availability and accessibility of sex for young people (through Apps like Tinder for example).
- Anti-trafficking measures that rely on the criminalization of sex work are fuelling regression on progress made in protecting sex workers from HIV and other STIs.
- The universality of the Sustainable Development Goals to be adopted in September 2015 has implications for the domestic policies of traditional donors. Increasingly, these actors will lose credibility if they advocate for action on inequality and other issues abroad when they are failing to address these at home.
- People increasingly have access to data and want to use it to be making better decisions. UNAIDS can outline ways to make good decisions using data.
- More and more, there is a shift in policy-making and resource allocation to resources being reoriented to where they are most needed according to data.

"Activism is hard work. It often goes unpaid and unappreciated. You get thrown into prisons. When you're an activist, you can't manage the bureaucracy of writing proposals and reports. Burnout is very high. How can you sustain that passion for so long without any resources? We need funding that recognises that street activism is just as essential as other day jobs."

Consultation participant

2. GLOBALLY, IN THE US AND IN NYC: WHAT ACHIEVEMENTS IN THE RESPONSE SHOULD BE EXPANDED AND BUILT UPON? WHERE ARE THE MAIN CHALLENGES AND GAPS? WHO IS BEING LEFT BEHIND AND WHY?

Successes

- Scaling up resources for AIDS has been the best investment in public health in low- and middle-income countries in recent years. There is now an opportunity to build on this trend.
- The AIDS response is well-placed in terms of the financing and other mechanisms that have been established to deal with the epidemic. The UNAIDS Programme Coordinating Board is one example and its multi-stakeholder composition is a good model that can be used to inform other responses.
- The Joint Programme is an innovative structure in the UN. UNAIDS was created to address the multi-faceted issues of the response not tackled elsewhere - i.e. 'the difficult stuff' and it should continue to demonstrate bold leadership on these issues. Its convening power, political role and advocacy should be scaled up.
- The investment framework was a good approach but it has not retained the focus it deserves. Such an approach could be reconsidered in the upcoming Strategy.
- The AIDS response has learnt and should continue to learn from good practices in other sectors. Best practice: For example, in education, data has informed evidence-based interventions for girls including girl-centred programming that builds assets for girls – numeracy, literacy, economic, safe places. This capacity building can be built on as a bottom-up approach to empower adolescent girls and key populations in the AIDS response – but only if combined with decriminalization as otherwise efforts are wasted.

Challenges and gaps

- Many populations and communities are being left behind. These include: women and girls (in particular in Eastern and Southern Africa), transgender women, transgender people, gender queer people and adolescents in general.

- Talking about 'ending' the epidemic can feel excluding to people living with HIV. This must be complemented with conversations on how to continue to support people living with HIV.
- One major gap in the response is adherence to ARVs in order to reach the level of suppression required to reach 90-90-90. Globally, adherence to ARVs is around 20%, in the US it is 25% and, in New York State, 50%.
- Viral suppression alone is not a sufficient outcome. HIV should not be framed exclusively as a medical issue; instead we need to take a holistic view of the health of individuals.
- Implementing integration is a major gap. It is easy to talk about but hard to do. We are not reaching out to other sectors and groups enough. Need to identify modalities for integration and incentives to make it happen.
- How to transfer lessons of what works from one jurisdiction to others is a challenge that requires further work.
- How to fund AIDS responses and development priorities in middle-income countries (MICs) is a major challenge. It is often assumed that national resources will step in but the departure of donors combined with countries not stepping up can lead to a 'fiscal cliff' and certain populations and programmes falling behind. Community response systems are crumbling in MICs where funding has been cut. This shows the need for flexibility in financing and a reassessment of the fitness for purpose of current income classification systems.
- Political support for HIV is decreasing and this poses major challenges to the AIDS community. Obtaining top level political support on human rights and what's unacceptable from a human rights perspective should also be prioritised.
- The issue of sexual orientation and sexual rights is currently highly polarized in intergovernmental fora. To make progress, we need to start a new narrative and talk in new terms about rights and sexual orientation.
- There is an advocacy gap that needs to be filled on comprehensive sexuality education.
- How to reflect and better address people's feelings in policy discourse is a challenge. As one participant said 'the cure for AIDS is kindness', but this is not often addressed. There should be more investment in peer-to-peer support and care.
- There is a mismatch between policy and reality. For example, policy has not kept up with changes in access to information through technology and social media – a 12 year old child can have a smart phone and in turn easy information about sex, but cannot get tested for HIV until they are 18 years old.

3. **HOW CAN THIS STRATEGY COMPLEMENT THE POST-2015 DEVELOPMENT AGENDA – IN PARTICULAR, WHAT DOES TRANSFORMATION LOOK LIKE IN THE AIDS RESPONSE? WHAT ARE THE IMPLICATIONS OF A UNIVERSAL AGENDA FOR THIS STRATEGY? AND WHAT ARE THE GAME CHANGERS NEEDED TO FUEL TRANSFORMATION?**

Game-changers for the response identified included:

- Putting human rights, decriminalization and combatting stigma and discrimination at the centre.
  - o Utilizing legal advocacy with a human rights framework to end criminalization around HIV and key populations including anti-trafficking measures that rely on the criminalization of sex work and addressing associated issues of policing.
  - o Taking a strong stance on the criminalization of consensual sex and consensual drug use on the basis that the AIDS epidemic cannot be addressed if this continues.
  - o Creating environments in which stigma and discrimination are not tolerated and are neither economically nor socially acceptable. Best practice: In New York State, transgender rights have been at the top of the agenda as the AIDS epidemic cannot end in New York without transgender people having their basic civil rights fulfilled.

- Implementing integration. Doing so was considered critical for the success of the post-2015 agenda and the UNAIDS Strategy which should both have integration at their core. Multiple dimensions to pursue were identified including:
  - Integrating service delivery within the health sphere, including with sexual health.
  - Working more closely with the UHC movement – bringing SRHR and HIV in as a way of being more ambitious than otherwise possible (can also open up resources for AIDS).
  - Ensuring better linkages across financing mechanisms so as to reduce fragmentation of financing.
  - Establishing allies/partners outside of the health sector – for example, those working on social protection, urbanization, education. This can also leverage additional resources for AIDS.
  - *Best practice:* In New York State, the promise of integration has made ending the AIDS epidemic seem possible. The robust structure established for AIDS is being converted to chronic diseases across the board. With prevention, integrating the diagnosis of HIV and other STIs has become the blueprint.
- Strengthening the role for civil society and people living with HIV and amplifying the voices of young people.
- Pushing boundaries with data and technology (including self-testing) to track adherence and viral suppression.
- Using HIV to elevate equity and social inclusion in broader discussions.
- Prioritizing structural interventions including housing, employment, food security measures, social protection and ensuring care and support. Expanding research around structural interventions should be prioritized in addition to research on medical interventions.
- Investing in capacity building.

Concrete recommendation: Revitalize and sustain activism including through establishing an 'emergency relief fund' for activists whose hard work often goes unpaid. The reality of activism means that there is no time for the bureaucracy associated with proposal and report writing and activists often compromise paid work in order to take action immediately.

Concrete recommendation: Change terminology from 'key populations' to populations that are 'over-burdened and under-served' on principle of know your epidemic, know your response. If we continue to use 'key populations', the case was made that women and girls should be included in this.

Concrete recommendation: Introduce a 4th '90' – 90% of people have programmes available to them so they can be tested safely, be on treatment and have support needed to achieve viral suppression.

4. WHAT WILL IT COST TO END AIDS, WHERE WILL THE RESOURCES COME FROM (INCLUDING FOR MIDDLE-INCOME COUNTRIES) AND HOW CAN WE ENGAGE THE PRIVATE SECTOR IN NEW WAYS?

- The AIDS response is an investment not a cost.
- Civil society/activists need to be adequately financed to effectively play their role and have greater impact.
- In order to maximize the chances of increasing resources for AIDS, the first step should be to make available detailed information on the current financing landscape in terms of what comes from which sources and where there is greatest potential for growth. This intelligence should then be cross-checked against an ideal scenario of how much funding should come from private and public sources respectively and a strategy for resource mobilization for the response developed accordingly. The role of ODA and its

relative significance in financing for development flows is changing and will continue to do so. It now occupies a relatively much smaller share in these flows and its role is becoming more targeted and catalytic. The Strategy should build on this and UNAIDS should steer the future direction of ODA including a greater focus on equity and leveraging the private sector through risk mitigation.

- Current financing mechanisms are dominated by donor voices and donor criteria. UNAIDS can be a champion in advocating for their reform.
- Innovative financing mechanisms that could be utilized for the AIDS response could include: calculating and reinvesting savings; co-benefits – how making savings in the epidemic can benefit the economy and how these savings can be reinvested; and social impact bonds.
- The Strategy should put in place mechanisms to ensure that sufficient funding accompanies the priorities agreed in the Strategy – there is no use of a Strategy that prioritizes vulnerable populations in theory if they are the first to stop getting funded when governments have to cut spending in times of austerity.
- We need to be realistic about how much additional resources we can expect for AIDS. Given the likelihood that ideal funding scenarios will not be met, scenarios should be developed for different levels of funding which identify priorities in each instance according to the resources available.
- Addressing structural issues gives more 'bang for your buck' – changing laws is cheaper than providing ARVs. Connected to this, seeding funding 'asks' in the SDG agenda could be a strategic way to make the overall ask more reasonable. For example, funding for essential medicines could be obtained through budgets for UHC or comprehensive sexuality education could be scaled up through funding for education. Political legacy arguments which make the case for investing in AIDS and social justice are needed. It is often the decisions that come from highest political leaders that have the greatest impact. Strategies to access Heads of States need to be developed.
- Question: What role does UNAIDS have in facilitating private sector involvement who want to contribute to financing, advocacy and other areas?

5. HOW CAN ACCESS BE EXPANDED THROUGH INNOVATION, NEW TECHNOLOGIES AND POLICIES, INCLUDING THOSE RELATED TO TRIPS AND R&D?

- Investing in R&D is critical but not enough.
- Long-term injectables are one of the most exciting prospects in this area.
- The Strategy should capture the research to roll-out continuum and how to operationalize a set of evolving interventions including self-testing, cash transfers and vaginal rings
- Making R&D and new technologies accessible to young people is a challenge. A stronger push is needed to educate people (particularly young people) about what science means, what it means to individuals and how to operationalize it.

6. WHAT ARE THE MOST CRITICAL WAYS IN WHICH THE UNAIDS JOINT PROGRAMME CAN SUPPORT EFFORTS – GLOBALLY, NATIONALLY AND IN NYC - TO END AIDS AS A PUBLIC HEALTH THREAT BY 2030?

On UNAIDS leadership:

- Strong call for UNAIDS to push political agendas and difficult topics, raising voice at political level, more strategic engagement around post-2015, CSW resolutions and other critical processes, including on:
  o Gender equality – call to become a strong champion on this in addition to UN Women
  o Elevating the equity agenda

- o Integrating health systems
- o Structural interventions
- o Outlining ways to make good decisions using data
- o Advocacy voice for key populations important as not many others champion the issues faced by these communities
- o Redefining ODA and steering its future

On UNAIDS ways of working:

- Participants made a strong call to reset the relationship between the Joint Programme and civil society. They called for recommendations on how to strengthen the relationship between civil society and both the Secretariat and its Cosponsors.
- Efforts should be made to leverage the resources and assets of the entire Joint Programme more effectively.
- The suggestion was made that the space of civil society in UNAIDS should be broadened.
- UNAIDS should make an effort to build alliances outside of the health sector with those most impacted by discrimination and inequality.
- UNAIDS should build on its convening role.

On the future of UNAIDS:

- Some participants advocated for UNAIDS to transition to a broader global health advocacy focus. The example of ACT UP demonstrating solidarity with Ebola was used to demonstrate that organizations currently dedicated to HIV could continue to work on intersections of vulnerability and continue to work with people who have been vulnerable to HIV infection. Other suggestions included that UNAIDS could become the UN Agency for Infectious Diseases or UN Intersectionality and Disease and maintain focus on combatting identity-based stigma.
- Other participants considered the AIDS response as an opportunity for the UN to set a new precedent and to demonstrate what it really means to deliver on a mandate, arguing that the logical knock-on effect of successfully ending the AIDS epidemic would be closing UNAIDS.
- In any case, participants emphasized that UNAIDS needs an exit strategy for after 2030 - not just closing shop but considering what support people living with HIV need and how the achievements of the movement can be leveraged for future health emergencies.

NEW YORK: PARTICIPANT LIST

1. Hassan Ahmad, Conscious Step
2. Heather Barclay, International Planned Parenthood Federation (IPPF)
3. Lauren Barredo, Sustainable Development Solutions Network (SDSN)
4. Marisa Anne Day, Sex Workers Outreach Project – NYC Chapter (SWOP-NYC)
5. Gillian Dolce, Global Youth Coalition on HIV/AIDS (GYCA)
6. Sarah Gold, International Women's Health Coalition (IWHC)
7. Catherine Hanssens, HIV Law and Policy
8. Ralf Jurgens, Open Society Foundations and Member of the UNAIDS Reference Group on HIV and Human Rights
9. Charles King, Housing Works and North American delegate on the NGO Delegation to the UNAIDS Programme Coordinating Board
10. Nana Kuo, Every Woman Every Child Team, Office of the UN Secretary-General
11. Surya Prakash Makarla, BCARE
12. Terry McGovern, Columbia University Mailman School of Public Health and Member of the UNAIDS Reference Group on HIV and Human Rights
13. Arne Naveke, International AIDS Vaccine Initiative (IAVI)
14. Naomi Rutenberg, Population Council
15. Andrew Spieldenner, US PLHIV Caucus
16. L'Orangelis Thomas, ICW Chapter for Young Women, Adolescents and Girls
17. Mitchell Warren, Global Advocacy for HIV Prevention (AVAC)
18. Jessica Whitbread, International Community of Women Living with HIV (ICW)

The Joint Programme was represented by the UNDP, UNFPA, UNICEF, and the UNAIDS Secretariat.

Discussion note
Regional Consultation on the UNAIDS Strategy 2016-2021:

EAST AND SOUTHERN AFRICA

23 March 2015, Johannesburg

KEY MESSAGES FOR UNAIDS STRATEGY

- Curbing **sexual transmission among young people**, particularly girls and young women, is vital: without this the epidemic will remain.
- **Expansion of treatment** has transformed how the epidemic manifests, is perceived and is responded to in the region.
- **Political commitment** for the hard choices, and for sustainability, remains essential; innovative ways must be identified to scale up investments and strategic information to better focus efforts on the populations and locations where the epidemic is concentrated.
- A comprehensive approach to **sexuality education**, along with longer-term approaches to address cultural norms and factors underlying gender inequalities, is essential to **empower young people.**
- **Key populations** remain under-served, under-involved and under-represented. Risks are exacerbated by stigma and discrimination.
- **Communities and civil society** must be supported in key roles in expanding and sustaining prevention, treatment, empowerment, and accountability.

SUMMARY

The consultation and opportunity to provide inputs to the UNAIDS Strategy 2016-2021 was welcomed by participants. Discussion was robust, thoughtful and direct. The region has a clear view of its priorities, and the directions it needs to go. There was a depth of experience in the AIDS response, from many perspectives, that now characterizes the region: Stakeholders know the regional epidemic, knows what drives it, have lived and worked to address it for decades and thus know what works. They don't expect any 'quick fixes', but are also quick to recognize changes in situation, circumstance and epidemiological reality, and respond to them. There is a strong sense that the region will emerge, eventually at the end of AIDS, better because of the response.

CONSULTATION METHODS

The main event was a one-day consultation held in Johannesburg on 23 March. The event consisted of plenary and group discussions to elicit answers to the 5 questions from the UNAIDS Discussion Paper (which was widely disseminated in advance), across seven themes identified as critical for the region: Prevention, Treatment, eMTCT, Human Rights and Social Justice, Gender, Community Engagement, Political Commitment and Sustainability. One hundred and seventeen (117) participants from across the region attended; from governments and programmes, civil society, communities, academia, and the UN family. In addition a High Level Ministerial Panel deliberated through the day and presented a High Level Political Agenda. The event was flanked by three constituency-specific consultations: an e-survey of civil society, a Human Rights and Social Justice Eastern and Southern Africa regional consultation, and an Eastern and Southern Africa Regional Treatment Forum. In advance, the International Disability and Development Consortium (IDDC) also submitted a draft discussion paper with regard to the pressing need for the better inclusion of people with disabilities.

Co-sponsors were closely involved in all elements: participants from regional (or sub-regional) offices of WHO, UNESCO, ILO, UNICEF, UNFPA, UNHCR, World Bank, UNODC and WFP participated in the One-day Consultation. Several also participated in the Treatment Forum and Human Rights and Social Justice Think-Tank. UNWOMEN provided a written submission. The Uganda UNAIDS country office submitted a country consultation report. The final draft report was circulated to all participants from the one-day consultation for review.

CONSULTATION QUESTIONS: DISCUSSION SUMMARY

1. **HOW WILL DEVELOPMENTS – GLOBALLY AND IN THE REGION – IMPACT THE EPIDEMIC AND RESPONSE IN THE REGION, SUB-REGIONS AND SPECIFIC COUNTRIES OVER THE NEXT SIX YEARS?**

The meeting started by recognizing that we are now living in a very different world to that which first recognized the HIV pandemic three decades ago:

- The **post-2015 SDGs,** although not yet finalized, present a new context for the AIDS response as AIDS is not a standalone goal. The SDGs are a call for action that we cannot work in isolation. They provide the opportunity for building on the unique lessons learned from the extraordinary AIDS response; and for building synergies with broader programs, in particular reproductive health, gender, and universal health coverage.
- **Flat-lining international resources,** competing development priorities, and new priorities for development investment pose a challenge for the sustainability of AIDS investments and preserving the gains made.
- Some countries in the region are graduating **to middle- and high middle-income level**, limiting their access to international resources - while this economic label can hide important inequalities in terms of poverty, development, and rights.
- **Health and community systems** are not at the same performance level in all countries, and particularly weak in **the fragile states**, where the AIDS response challenges are compounded by security issues and humanitarian crises. The Ebola crisis to our West has shown how vitally important health and community systems and governance are, and the critical role of the trust people have in their governments.

In their detailed discussions, the participants expanded on further critical changes are taking place in the region:
- **The biggest contextual change in the region is the expansion of ART, with 8.1 million people on treatment and 78% PMTCT coverage**. This is having an impact in many ways: health services have been challenged and in many ways transformed by the demands of treatment. Quite apart from sheer burden of demand and numbers, diagnostic and treatment innovations, task-shifting and simplified regimens, a more holistic approach to patients, M-health and communications technology, and increasing integration of services are becoming more common and increasing access to services. A variety of new service delivery approaches are having to be developed: for adolescents living with HIV, both in and out of school, for pediatric cases, requiring household level support, and for community services and support groups as ART gets closer to communities. These challenges and changes will continue with the need to improve retention and adherence, and to ensure people maintain an undetectable viral load.
- **Of particular importance and concern for the region, however, is that while new infections have decreased in all countries, the face of HIV has changed. It is now predominantly one of young women and adolescents**: 50% of the deaths from AIDS are among adolescents. In 2013, HIV incidence across countries in the region was high

among women in their late teens and early 20s. This equated to 4300 new HIV infections among young women aged 15-24 years per week among 14 ESA countries. This means we must target prevention programmes where they are most needed: comprehensive sexuality education that will equip young people to make good choices. As one participant noted, "young people today do not know that AIDS kills". We must address the under-lying social and cultural norms that pre-determine gender roles, support gender inequality, and undermine prevention.

- **There have been significant improvements in gender awareness, understanding of the role gender plays and the need for gender equality, and gender-sensitive planning and programming**; both in general, and specifically with regard to HIV - but there is still far to go. How to fit gender and HIV into the SDG framework will be a challenge: within this larger framework HIV is losing attention, while gender is gaining attention. The paradigm now is shifting "from gender in HIV to HIV in gender".

- For civil society the context has changed significantly: the 'normalisation' of treatment has meant that **HIV can become a chronic illness** that can be managed in the community. PLWH are now living without the 'fear of death from AIDS', and implementing a range of prevention and care programmes, and making a difference in their communities. It is important for civil society to help communities adapt to these changes. Yet while GF support has created great space for civil society, increases in domestic contributions don't necessarily flow to civil society, and tend to be predominantly for government programmes.

- **Decentralisation is increasing** throughout the region. There are advantages of decentralization, but also challenges. Nobody knows the epidemic better than those at the local level of managing, planning, and financing; districts can also be encouraged to use their own resources. But, this will require major administrative, bureaucratic, legal and regulatory system changes; how can these be achieved without risking the gains of present systems?

- At both regional and global level there has been increased **recognition of the need to integrate human rights, social justice, participation and equity** within broader goals for universal health coverage. These are among the 'critical enablers' of HIV programming, and thus provide scope for improved, and more focused interventions; there is still a long way to go, however. Political commitment, evidence to inform good policy-making, and social transformation will all be needed if these gains are to be realised.

- **Decreased donor funding has highlighted critical sustainability issues**. While some countries can afford to allocate more of their domestic resources for HIV, some will continue to require long-term external support. Countries are slowly recognising the need to make their programming more sustainable, both with regard to systems building, and in financing. How to maximise and balance opportunities for increasing domestic funding for issues that are sometimes seen as unpopular to fund? How to strengthen health, education and social support systems to play a stronger role in HIV programming? How to be more efficient and effective in using available funding?

2. **WHAT ACHIEVEMENTS OF THE REGIONAL RESPONSE SHOULD BE EXPANDED AND BUILT UPON? WHERE ARE THE MAIN CHALLENGES AND GAPS? WHO IS BEING LEFT BEHIND AND WHY?**

- A number of prevention programmes have been successful around the region (quotes in parenthesis are from consultation participants), including : i) community engagement ("we have killed off stigma and discrimination, which has allowed more access"); ii) changing sexual behaviours (reducing multiple concurrent partners, delaying sexual debut); iii) male circumcision, particularly among younger men; iv) peer education ("The

central role of peers in how individuals respond cannot be overstated"); v) condom distribution ("Condoms work"); vi) engaging governments, parliamentarians, etc; multi-sectoral approaches ("We can't stop with the AIDS service providers; we must also reach police officers, judges, those who work in drug control"). But much better evidence of just how these prevention programmes work, and what aspects work best, is required. We need to ask what prevention programmes have not been successful, and do less of such activities; and what works well, and do more.

- Many people including key populations, adolescents and communities in remote and hard to reach areas are being left behind: internal mobile populations, young people not in school, young people at 'hot-spots' of highly risky behavior, girls and young women at risk of sexual abuse and violence, MSM, TG and sex workers, traditional leaders as role models, workers in the informal economy, persons with disabilities. Prevention programmes need to become more focused, and more targeted at these groups; we need not only to design programmes that will reach these groups, but also ensure that they are attractive and acceptable to these groups
- HIV testing remains low despite rapid scale up - only 45% of people living with HIV know their HIV status and only 10% of young men and 15% of young women (15–24 years) were aware of their HIV status in 2013.
- 41% of all PLHIV in the ESA region were on treatment at the end of 2013 – a major achievement, but still inadequate, with significant variation in coverage among countries and within countries. People are being left behind in the roll-out of treatment: people with disabilities, those living in remote areas (such as fishing sites), refugees and IDPs who fear to access services, adolescents in boarding schools, prisoners and women who do not normally access health services, even for delivery. Services must be expanded and extended to reach all these people. In addition, with increasing access to services, quality of service delivery needs to be maintained – this can be costly and challenging.
- The growth and empowerment of civil society and community level engagement is a vital area to build on and take forward. "A few years back when the health could not cope, it was community systems that responded; communities provided care when it was needed when the biomedical side was overwhelmed; community structures of various kinds played a big role." These need to be built upon to support issues of adherence, stigma demand creation, advocacy, engagement and accountability. In addition, community-driven prevention regarding cultural norms and practices is something that can be done effectively through community level engagement and by the civil society
- Key drivers of the epidemic for women and girls, are grounded in cultural norms and practices, are multi-layered and mutually reinforcing - but also preventable. These drivers include the unequal relations between women and men, and socio-cultural norms and practices. Gender thus remains a major issue, and while increasingly visible and recognized, it is still highly neglected. The lack of awareness, visibility and commitment to gender equality, harmful gender norms, women's and girl's agency and empowerment, sexuality, and the elimination of gender-based violence was highlighted. While there has been some progress with gender responsive policies and legislation, political commitment, strategic information, and economic empowerment programmes (such as social protection, cash transfers, livelihood interventions) all these need to be substantially built on and strengthened. Adolescents and young women and girls, particularly girls not in school, are especially neglected.
- There is increased understanding and evidence of structural drivers and the role of human rights, social justice, participation and equity in responses to HIV in the region. Some levels of increased commitment and integration of this can be seen in national, regional and global strategies, policies, plans, programmes and interventions; and some successes in improving human rights, social justice, participation and equity. There remain, however, significant gaps in the evidence, understanding, inclusion and prioritisation of specific populations.

- There are gaps in strengthening platforms for broader social justice movements as well as significant gaps in allocation of resources and implementation of concrete actions (e.g. law review, social protection) to strengthen the rights of key populations and promote human rights, social justice, participation and equity.

3. IN ORDER TO REACH THE FAST-TRACK TARGETS, WHAT SHOULD BE THE REGION'S STRATEGIC PRIORITIES IN THE RESPONSE?

- Addressing the needs of adolescents and young women and girls is a vital priority. Re-energizing the prevention focus for these groups, re-directing resources for them, re-vamping political commitment to them, and overall re-socialising of men, women, boys and girls is a fundamental key to prevention in the region.
- For treatment the most important thing is to strengthen the health systems to build upon scale-up of treatment. Laboratory capacity, point of care diagnostics, service integration (HIV/TB, SRH, MNCH), task-shifting and community involvement all need to be strengthened, along with human resources, procurement and supply chain management, data management and evaluation and use of dashboards and integrated palliative care. A drastic focus on children is necessary with coverage at only 27% in the region.
- Continuing to build evidence across the board is a priority; increasingly accurate identification of key populations; of what works and what doesn't; pushing for concrete implementation and action based on evidence and focussing efforts on those issues that have been shown to work (e.g. social protection, law review, improved law enforcement). Countries need to strengthen the generation and use of evidence on efficiency to inform resource allocation and strategic policy shifts; and strengthen the tracking of and accountability for resources.
- Increased political commitment and leadership on the "hard issues" is needed, addressing the 'critical enablers', such as human rights, the legal environment, and the chain of accountability. Countries need to promote better harmonisation of laws and legal frameworks, policies, strategies and budgets to address sub-regional and cross border issues. Some countries which are key to meeting the region's Fast Track goals, also fall within the category of countries with newly discovered mineral wealth; working with the private sector in the extractives industry in countries has the potential to reap multiple benefits.
- We need a commitment to change socio-cultural norms and practices with regard to young people and women. Given the role that cultural and community leadership (eg chiefs) can play in advocating against harmful cultural practices, including cultural norms and adherence to laws which outlaw these practices, there is potential to partner with this category of leaders. The African Queens and Women Cultural Leaders Network (AQWCLN) is one key network; male cultural leaders are also important actors in enforcing understandings of permissible cultural norms and practices. For example, in Malawi, the traditional leaders advocated for the raising of the legal age of marriage in Malawi from 15 to 21 years of age and many have established laws in their own districts setting the minimum marriage age for a girl at 21.
- Addressing the needs of key populations, such as MSM, transgender populations, sex workers, people who use drugs, adolescents and children, women, people with disabilities, migrants and refugees) is essential. A prioritized strategic approach needs to advocate for the explicit inclusion of such key populations into all parts of HIV prevention: behavioural interventions, condom promotion, accessibility of information, medical male circumcision and prevention of mother-to-child transmission. We must commit to making equality and universal access to services a reality for these populations, and pragmatically manage the social, cultural, economic and legal obstacles.
- A number of opportunities to address sustainability issues were identified. The SADC Action Framework on Sustainability and the on-going EAC Sustainability analysis present an opportunity for the region to increase focus on sustainability; efficiency and

cost benefit analysis which has captured private sector interest, increasing their willingness to finance health programmes; country level mobilisation of the private sector using available national business coalitions; regional initiatives to promote drug pooling/pooled procurement; work ongoing in 16 countries to mainstream and integrate HIV, Health and Gender in Capital development which should be harnessed to improve health financing; and the existence of regional initiatives - The SADC Trust Fund, SADC HIV/TB initiative etc. These will need to be carefully coordinated to minimize duplication of effort.

4. WHAT WILL NEED TO CHANGE IN SUPPORT OF THOSE PRIORITIES? WHAT ARE THE "GAME-CHANGERS" – IN TERMS OF POLICY AND LAW REFORM, FUNDING, RESOURCE ALLOCATION, PARTNERSHIPS, SERVICE DELIVERY, EMPOWERING CIVIL SOCIETY, SCIENCE AND INNOVATION, AND LINKS WITH OTHER HEALTH AND DEVELOPMENT EFFORTS?

A new paradigm for the AIDS response is required in the region to accelerate implementation where the gaps are and leave no one behind. This means focusing on ensuring effective implementation and service delivery of the right programs, at the right place, for the right people, at the right time.

- **Re-invigorating prevention**: Success or failure in preventing sexual transmission in the region is the defining factor towards the vision of zero new HIV infections. Prevention of sexual transmission must be re-vitalised and focused where new infections are taking place. We need both specific prevention programmes (eg comprehensive sexuality education, condom distribution, etc) and broader programmes that address the drivers and under-lying norms - to 're-socialise' boys and young men, empower girls and young women, and re-calibrate the mind-sets of adults and leaders.
- **Investing in young people, with a particular focus on young women and girls is vitally important.** A number of new initiatives have started – "All In", recently launched under the leadership of UNICEF and PEPFAR's "Dreams" initiative will accelerate the response for adolescents and young people in the region. Comprehensive sexuality education is gathering momentum; this will help address structural factors at community level to reduce gender-based violence, ensure gender equality and build resilient, educated and independent young women. Young men must not be forgotten: prevalence among young men rises at about the same rate as among young women but approximately 5 years later. Countries are investing resources in Voluntary Medical Male Circumcision; however, uptake and demand remains low, with only five million men/boys circumcised thus far against a target of 21 million by 2015.
- **Urbanization** is an evolving phenomenon in ESA countries that brings development and vulnerabilities. Cities in many countries are not only disproportionally affected by the HIV epidemic but often have large informal areas in which HIV prevalence is often high and heightened vulnerabilities. It is imperative that partnerships are established with local government and civil society and the institutional structures of cities to identify and implement a locally designed response in the high-burden cities.
- To live up to **substantial and growing financing** needs and achieve a sustainable response, we need to follow two paths: be more effective with available resources and develop innovative financing mechanisms: such as the new initiative between SADC Ministers of Health and the private sector in establishing a Health Trust Fund.
- **Partnership** to articulate, address and resolve the needs of our region is essential. Partnerships need to be strengthened and expanded, and effective platforms for sustaining them put in place.

5. **WHAT ARE THE MOST CRITICAL WAYS IN WHICH THE UNAIDS JOINT PROGRAMME CAN SUPPORT EFFORTS IN THE REGION TO END AIDS AS A PUBLIC HEALTH THREAT BY 2030?**

▪ A vital role for the UN regards **evidence**: helping to generate evidence, model strategies, analyse contexts and support ownership of evidence-informed strategies. The group called upon UNAIDS to develop a robust monitoring plan to follow-up on country progress in achieving goals and priorities. It will be particularly important to ensure age and sex disaggregation in all data; to improve GBV data, and to support the institutionalisation of these institutionalised in country M&E systems. The Ministers called on UNAIDS "To inform us about evidence-based interventions, what works and doesn't work, and high-impact interventions, so we know where to put the money to get the highest impact."

▪ A key role for the UN will be **capacity strengthening and technical support** at national level, to amplify local voices, build accountability, strengthen coordination. The UN can create space for young people (especially young women and girls) to contribute and participate. This is also needed at regional level, facilitating platforms to bring a range of organisations and sectors together, with high-level advocacy for sustainable financing and ownership, and accountability for action.

▪ UNAIDS should support the **capacity-building of civil society organisations and communities** to implement programmes and support the investment in a dashboard and situation room to track programmatic progress and enable real-time monitoring on a national basis.

▪ UNAIDS should use its convening role to **bring together diverse partners** and use the credibility of the UN/UNAIDS to influence political leaders.

Additional Issues Raised During the Consultation Process

From the High-Level Ministerial Group and Panel: We have to recognize key populations and work through the structures that bring services closer to these populations. We need to develop formal contracts with civil society organizations to implement programmes, which governments should fund.

Focus on local-level HIV epidemic dynamics: SADC and the Intergovernmental Authority on Development (IGAD) should bring common cross-border issues to the ministers as a joint agenda: "Let's have one common and formalized agenda" for all the cross-border issues (truck drivers, fisher-folk), zooming in on the specific communities."

Demystify HIV: "It is cheaper to talk about it and break the norms now than to treat tomorrow."

Support First Ladies and Champions: who can be advocates with high political leaders. We should empower traditional and community leaders to be "the champions" of the change we want to see, rather than start implementing our programs themselves.

Domestic Financing – Owning the Agenda: "We need to be champions to increase domestic financing, because by putting money on health we strengthen political and social capital." The utilisation of resources is as important as raising the funds: "We need to set our priorities right; when we talk about strengthening service delivery, we need to put our money behind it." Also, we need to give ourselves targets for domestic financing, including small targets and milestones (in addition to convincing the Ministry of Finance to expand domestic funding), and be accountable for the rhetoric to foment action. We also need to share our plans and targets with partners at the regional level for feedback.

EAST AND SOUTHERN AFRICA: LIST OF PARTICIPANTS

Angola
ANASO Angola

Botswana
Champions for an AIDS-Free Generation
NACA Botswana

Ethiopia
Africa Civil Society Health Partnership Forum
National Network of Positive women in Ethiopia
ASLM

Kenya
KELIN
International AIDS Alliance
Ministry of Health
PAPWC
HUAIROU Commission of the Global Coalition of Women and AIDS
ISHTAR MSM

Lesotho
Lesotho Network of AIDS Service Organizations (ENASO)
Young Positive Network

Madagascar
National AIDS Committee

Malawi
NAC Malawi
Elizabeth Glaser Pediatric AIDS Foundation
MANERELA+

Mozambique
Civil Society Platform

Nambia
Positive Vibes
Ministry of Health and Social Services
AfriYAN Namibia

Seychelles
Ravane Océan Indien
Ministry of Health

South Africa
SANAC
Embassy of Finland

GIZ
Network of African People Living Positively, African Region (NAP+SAR)
Standard Bank
MSF Belgium, South Africa
Canadian Government
SABCOHA – South African Business Coalition on Health & AIDS
Mothers2Mothers
Swedish Workplace HIV/AIDS Programme
Sonke Gender Justice
Aids and Rights Alliance Southern Africa (ARASA)
RIATT
International Children's Palliative Care Network
SAfaids
Irish Aid/Embassy of Ireland
IOM
AIDS Accountability International
ICWSA (in full)
Regional Psychological Support Initiative (REPSSI)
DFID Regional Office
International Children's Palliative Care Network
Swiss Agency for Development and Cooperation
SANAC
National Network of Religious Leaders Living with and Personally Affected by HIV and AIDS, Africa Region (INERELA+/Africa)
Human Science Research Council (HSRC)
CABSA
Out of Phase Facilitation, Consulting, and Support Services

South Sudan
South Sudan AIDS Commission (SSAC)

South Africa, Swaziland
Voluntary Services Overseas- Regional AIDS Initiative Southern Africa (VSO-RAISA)

Swaziland
Ministry of Health

Tanzania
Tanzania Commission for AIDS
(TACAIDS)
Eastern Africa National Networks of AIDS
Service Organizations (EANNASO)

Uganda
Uganda Youth Coalition on Adolescent
Sexual and Reproductive Health Rights
and HIV/AIDS (CYSRA-Uganda),
IOM
ICW and Mama's Club

Zambia
Government of Zambia
National HIV/AIDS/STI and TB Council

Zambia - Mayor of Lusaka
AFROCAB

Zimbabwe
Youth Engage, Zimbabwe
SAfaids
Widows Fountain of Life (WFoL)
PATAM
NAC Zimbabwe
Disability HIV and AIDS Trust (DHAT)
PAPWC

USA
Health Gap

Discussion note
Consultation on the UNAIDS Strategy 2016-2021:

ASIA AND THE PACIFIC

26 March 2015, UNAIDS, RSTAP

"UNAIDS Strategy comes at critical time when SDGs will be finalised, so the next 5 years are critical to build a strong foundation to end aids by 2030. We have the necessary tool to end the epidemic but we do need strong political will to do that. We need to end AIDSin our time and not to leave it as a burden to our grandchildren's generation."

H.E Ratu Epeli Nailatikau, President of Fiji

KEY MESSAGES ON UNAIDS STRATEGY

The UNAIDS Strategy should seek to accomplish the following:

- Remain **ambitious, innovative**, while still having achievable targets and produce a practical roadmap, and accountability mechanisms for greater efficiency in implementation of the strategy
- **Maintain the three zeros** at the core of the strategy and build on **three strategic directions and goals**
- **Introduce innovative approaches to** put new evidence, science and knowledge in practice (community-based testing, early treatment initiation, PrEP for MSM and others).
- Reinforce relationship between **prevention, rights and treatment,** empower and engage and build partnership of **civil society organizations (CSOs), key populations and government**
- **Focus on high burden countries and cities:** Over 1.2 million PLHIV live in 30 Asian cities, cities must be engines of progress, change and rapid scale up.
- Promote an **investment approach and support countries to manage transition** from donor to domestic financing.
- Support countries to strengthen **specification of priorities** and aspects for decentralized implementation, supported by evidence and strategic information based on disaggregated data for key populations.
- Integrate HIV issues with **broader social and economic aspirations** of marginalised communities
- Engage with **regional political bodies** to promote accountability, south-south cooperation

EXECUTIVE SUMMARY

The CSOs survey suggested five game changers for the future UNAIDS strategy which includes:

1. Expansion of community based testing and treatment
2. Emphasis on New Prevention Technologies incl. Prep, integration of HIV and SRH integration
3. Sustainable financing mechanism
4. Legal reform to eliminate stigma discrimination and to create an enabling environment for their access to services
5. Empowering CSOs including their financial sustainability and engagement in decision making processes.

Key calls related to youth that arose from the consultations include: a) Gender sensitive approaches especially KP, b) Clear linkages of HIV/KP issues in post 2015 AIDS agenda c) Effective use of UNAIDS human resources d) Close the funding gap of KP, e) Better community strategic information f) Stronger messages to government on criminalization of KP g) Flexible deliver of HIV testing Accessible quality ARV and h) Recognize the contribution of KP networks.

CONSULTATION METHODS

The Asia and Pacific Regional Support Team followed an inclusive approach to obtaining multi-stakeholder input for UNAIDS strategy for 2016-2021. Processes included:

- The AP Regional Perspectives on UNAIDS Strategy 2016-2021 consultation, held as a side event to the ESCAP IGM on HIV/AIDS on January 30, Bangkok, was attended by 160 participants from 32 ESCAP member and associate member countries from government (MOH, MOFA, MO Law &Justice, MO Interior), UN agencies, ASEAN, SAARC, IOM, PP, and NGOs representatives of 79 CSOs.
- Two informal exchange of views on UNAIDS Strategy and UBRAF with participants from ASEAN and SAARC countries, ASEAN and SAARC Secretariat, NAP, MOH and MO Justice, Parliamentarians and NGOs.
- Two discussion sessions with UN regional cosponsors (UNRITA), and
- CSO-UNAIDS joint online survey.

FIVE CONSULTATION QUESTIONS: DISCUSSION SUMMARY

1. HOW WILL DEVELOPMENTS – GLOBALLY AND IN THE REGION – IMPACT THE EPIDEMIC AND RESPONSE IN THE REGION, SUB-REGIONS AND SPECIFIC COUNTRIES OVER THE NEXT SIX YEARS?

Nearly all countries across the region have enjoyed sustained economic growth ranging 4 to 8%, driving countries' movement from low- (LIC) to middle-income country (MIC) status and impacting eligibility for donor funding. Donors support in almost all countries is shrinking or even withdrawing, which has implications for the regional AIDS response and particularly continued support for high-impact interventions for key populations and engagement of CSOs.

The UNAIDS strategy should reflect the regional need to shift to domestic resources especially for LICs moving to MIC status. It should present a clear transition plan from external to domestic resources for sustainable AIDS responses especially to ensure stable funding for key populations.

There is a rising conservatism in the region, which is a potential challenge for addressing the needs of key and marginalized populations. It is important that the strategy promote activism to address such challenges in the region.
With the current global focus on Universal Health Coverage, maintaining attention to HIV and ensuring continuum of services is key for fast-tracking AIDS responses in post-2015. UNAIDS strategy must address Universal Health Coverage in a way that does not leave any people behind regardless of gender, age, race, or sexual orientation.

As a result of domestic economic growth and globalization, the region is experiencing rapid urbanization leading to increased mobility and migration within and between countries, within

and beyond the region. For example mobility and migration in the ASEAN Community, South Korea and Middle East countries have an impact on the responses. Access to prevention and treatment services for mobile and migrant populations is an important issue to be addressed in the future UNAIDS strategy through promoting and strengthening regional cooperation.

There is concern that notable progress made in the region's overall AIDS response will lead to complacency, which needs to be addressed through strong political advocacy built in the future UNAIDS strategy.

2. WHAT ACHIEVEMENTS OF THE REGIONAL RESPONSE SHOULD BE EXPANDED AND BUILT UPON? WHERE ARE THE MAIN CHALLENGES AND GAPS? WHO IS BEING LEFT BEHIND AND WHY?

Prevention

Annual new HIV infections declined by 6% from 2005 to 2013, and have stagnated over the last several years around 350,000. The region has had some success in reducing new HIV infections among sex workers. Among other key populations, however, including MSM, PWID and TGs, new infections are on the rise. Reaching intimate partners of key populations is an important issue, yet in general there is lack of evidence and best practice.

The new strategy needs to focus on concentrated epidemics in hotspots, cities, among key populations, marginalized women with PMTCT services, and ensuring attention to HIV in the sexual and reproductive health (SRH) context. This will require positioning global AIDS responses to broker the right partnerships and scaling up our programmatic experience to KP. However, political will on the issues of addressing the need for CSO, Sexual Orientation and Gender Identification (SOGI) and forced abortion to female PLHIV still remains a challenge.

Efforts in the region to reach and support youth members of key populations are among the most effective in the world. There is still a critical gap however in strategic information, particularly on people younger than 18 years, parental consent laws and practices and legal barriers. UNAIDS new strategy should build on the current momentum. Another population often left behind in the region is prisoners and people in closed settings.

Treatment

By the end of 2013, approximately 1.6 million people were receiving treatment, or 33% of all people living with HIV the Asia and the Pacific, marking a 23% increase in 2012-2013. A 27% decline in AIDS-related deaths since 2005 was achieved. ART coverage is still low in most countries in Asia (with a few exceptions) both for the general population and for key populations. Adherence to care and the provision of a package of services tailored to the needs of people living with HIV are also remain as important challenges/gaps.

The new strategy needs to lead on how to identify key populations and the most effective, rights-based interventions for various populations and communities, differentiating target populations and concrete prioritization for prevention and treatment.

Enabling environment

Nineteen countries reviewed national laws and policies and continued dialogue on improving legal environments that support an effective AIDS response. Sindh province in Pakistan passed Sindh Provincial AIDS Law while other countries tabled the proposed law.

Bangladesh, India, Nepal and Pakistan governments recognised transgender/hijra as third gender.

International Labour Organizations work on conditions, safety and access to health service for SWs in the region. The Cambodia Ministry of Labour issued a policy of full protection to entertainment workers under national labour law.

The Government of Australia recently confirmed the lifting of all restrictions related to the travel of people living with HIV.

As mentioned earlier despite notable progress there are signs of increased conservatism. The new strategy must generate stronger political advocacy for enabling environments and a gender-sensitive and human rights-based approach that addresses the need and rights of MSM, SOGI etc. in post-2015 AIDS responses.

Shared responsibility

There is significant progress in increasing domestic contributions. In 2013 the proportion of AIDS funding from domestic sources was 57% in comparison to the global average of 52%. However proportionate allocation for priority interventions on prevention, treatment, care, and enabling environments is a challenge that needs to be clearly addressed in the UNAIDS strategy, as well as guidance to countries on smart investments and maximum returns from scares resources.

The region has been generating quality Strategic Information that has benefitted Cosponsors, CSOs and other stakeholders in designing specific interventions and Global Fund New Funding Model concept note submission. The new UNAIDS strategy needs to consider that globally prescribed epidemic models are not consistent with work in the AP region; several countries are using the AIDS Epidemic Model of East-West Center.

3. IN ORDER TO REACH THE FAST-TRACK TARGETS, WHAT SHOULD THE REGION'S STRATEGIC PRIORITIES IN THE RESPONSE BE?

The first thing to do is select and focus on high burden countries such as **China, India, Indonesia, Pakistan and Viet Nam** which will enable achieving maximum results with minimum investment. In addition to countries, **geographic prioritization** within countries including cities and hotspots can help fast track the responses. The new strategy should present stronger messages and approaches on reaching KPs (SW, MSM, PWID, TG, Youth, Adolescents, Migratns and Mobile populations).

Managing the transition in the region from donor to domestic financing is a priority for sustainable AIDS responses using the principles of shared responsibility through fiscal and health programme analysis. Countries need to get out of the box to increase domestic financing including through innovative and taxation schemes. An increased role of the private sector in service delivery is also a critical component of sustainable AIDS response. The new strategy needs to promote efficiency and gains through investing in tailored prevention and treatment programmes for key populations. The Strategy should seek to ensure that health insurance schemes in support of UHC cover HIV treatment.

Strengthening the Health Service delivery system is a key issue to address treatment in the health system. The new strategy should use the opportunity to push health sector reform issues under UHC in the SDG.
Mainstreaming: The new strategy for HIV should reflect integration and mainstreaming of the response across sectors. This is critical for "leaving no one behind" – the health sector

alone will not be able to address the diverse issues of gender inequality, human rights, and HIV financing among others. The strategy also should address the needs of low risk women in the region.

Improving the policy and legal environment including removing barriers to access to services by anyone should be the central focus of the new strategy policy. Need to analyze the **cost of inaction** on an enabling environment.

Governance of the AIDS response needs to be addressed by the new strategy, especially how to ensure space **for CSO advocacy** and their engagement in shaping national responses.

4. **WHAT WILL NEED TO CHANGE IN SUPPORT OF THOSE PRIORITIES? WHAT ARE THE "GAME-CHANGERS" – IN TERMS OF POLICY AND LAW REFORM, FUNDING, RESOURCE ALLOCATION, PARTNERSHIPS, SERVICE DELIVERY, EMPOWERING CIVIL SOCIETY, SCIENCE AND INNOVATION, AND LINKS WITH OTHER HEALTH AND DEVELOPMENT EFFORTS?**

- **Fast tracking** in selected high burden countries and then for all countries
- **City focus:** Over 1.2 million PLHIV live in 30 Asian cities— cities must be engines of progress, change and rapid scale up
- **Geographic prioritization** including cities and hotspots and **a decentralized approach,** supported by evidence and strategic information with disaggregated data for hotspots and key populations
- **Leave no one behind** including PWID, MSM, SWs, TG, prison populations, migrants, women and girls, adolescents, youth
- **Innovation to** put new evidence, science and knowledge into practice (community-based testing, early treatment initiation, PrEP for MSM and others)
- **Promoting UHC and financing** – and ensuring that HIV treatment is included in UHC programmes
- **Removing legal and policy barriers** to access services, etc. Do more at local level. **Look at cost of inaction (analysis)**, health economics, cost of contradiction in harm reduction etc.
- **Investment approach/Managing transition**: the region's transition from donors to domestic financing

5. **WHAT ARE THE MOST CRITICAL WAYS IN WHICH THE UNAIDS JOINT PROGRAMME CAN SUPPORT EFFORTS IN THE REGION TO END AIDS AS A PUBLIC HEALTH THREAT BY 2030?**

- Strengthen coordinating, facilitating, supporting and brokering role at the regional level to build coherent and comprehensive partnerships with donors, Cosponsors, CSOs and other key stakeholders, while maintaining the current mechanism of UNRITA and Extended Partnership Forum.
- Facilitate partnerships at the country level, coordinate actions of national and international stakeholders, and facilitate a funding mechanism for CSOs especially in Vietnam and China where there is no such mechanism.
- Support South-South Cooperation, sharing what's working and what's not. Engage sub-regional inter-governmental organizations such as ASEAN, SAARC, and PIF.
- Promote TRIPS flexibilities and Free Trade Agreements for availability of affordable medicines, (India might have less flexibilities).
- Continued high level political advocacy in creating enabling environments, protecting human rights and resource mobilization.
- Gradually prepare a fast-track plan for all countries.

Discussion note
Regional Consultation on UNAIDS Strategy 2016-2021:

WESTERN EUROPE

26-27 March, Montreux, Switzerland

"We need a new narrative on HIV in Western Europe. There is no evidence or rationale for complacency. We need a sense of urgency; we need to do more to communicate, to break through and get the message out that AIDS is not over."

"We have one of the best opportunities to set the next agenda. What we are really looking for is a new AIDS movement. This is the moment for Western Europe to take control of its own epidemic—this will help to mobilize the action elsewhere and on the global stage."

Consultation participants

KEY MESSAGES ON UNAIDS STRATEGY

A number of priority strategic actions emerged from this consultation:

- **Recognize that AIDS is not over in any region, anywhere, including in Western Europe** – Despite successes, worrying trends and gaps in responses are emerging.
- **Keep HIV high on the political agenda** – Communicating on risks of not investing in AIDS, combatting complacency and a new regional narrative are critical.
- **Realise shared responsibility and global solidarity** – Obligation to regional and global response. Shift from "expenditure" to "investment". Enable new resource streams, including public private partnerships.
- **Address inequality and exclusion** – European strategies need to be flexible to address changing dynamics, e.g. inequality in MICs, migration and young people within high risk groups.
- **Revive AIDS movement and invest in civil society** – Civil society and community networks need to be more central in the delivery of services, and in reaching out to constituents to inform, empower and link to care. Activism role should be funded as global public good.
- **Build on synergies** – Utilise potential of AIDS as entry point to deliver multiplier effects across development, equality and rights.
- **Expand partnerships** – Improve cross-sectoral mobilization and action across governments, EU, EC, civil society, UN and other partners.
- **Strengthen data-driven planning** – Data needs to evolve to provide real-time information for population and geographical granularity and inform planning for services that are acceptable and accessible.
- **Utilise new tools** – Use of new technologies e.g. social media can expand targeted HIV prevention and outreach particularly among key pops and youth.

EXECUTIVE SUMMARY

The UNAIDS Strategy consultation for the Western Europe region was hosted by the Government of Switzerland on 26-27 March in Montreux, Switzerland. The consultation brought together around 40 representatives of government, civil society and technical partners. Invitations were extended to all Geneva-based missions, requesting participation of governmental representatives. Civil society participants were selected through consultation

with key population networks in the region, advice from the PCB NGO Delegation and with attention to ensure gender, population group, and regional balance. The UNAIDS strategy background paper was circulated to all participants in advance of the consultation.

In the capacity of Switzerland as Vice-chair of the UNAIDS Programme Coordinating Board, Ambassador Alexandre Fasel, Permanent Representative of Switzerland to the United Nations in Geneva gave opening remarks. Key remarks were also given by UNAIDS Deputy Executive Directors Ms Jan Beagle and Dr Luiz Loures. Dr Andrew Amato from the European Centres for Disease Control (ECDC) gave an overview on the HIV epidemic and response in Europe and Dr Kent Buse gave an overview presentation on updating and extending the UNAIDS Strategy for the 2016-2021 period.

The consultation chose to focus on:

- Status overview of HIV epidemic trends in Western Europe
- Achievements, challenges and gaps in the regional response, and global and regional developments that are expected to impact the AIDS response in the region
- Priorities and game-changers to end the AIDS epidemic in the region by 2030
- The role of UNAIDS for the region.

The AIDS response in Western Europe has validated the three strategic directions of the UNAIDS Strategy which need to be built upon, in a more nuanced way, in the next phase. The updated and extended strategy will be key to moving the response forward in the next period and represents a window of opportunity to reinvigorate the Western European response. The 5 'I' cross-cutting issues that are proposed for the updated Strategy (Information; Integration; Innovation; Investment; Inclusion) resonate with the majority of issues raised through the consultation and provide a useful framework to drive the next phase of the strategy.

Western Europe plays a dual role in the AIDS response: meeting the needs of its own populations, and supporting the broader global AIDS movement. In this sense, Western Europe has a major role to play in taking the UNAIDS Strategy to the next level for the region, and for the world.

FOUR CONSULTATION QUESTIONS: DISCUSSION SUMMARY

1. WHAT ACHIEVEMENTS OF THE REGIONAL RESPONSE SHOULD BE EXPANDED AND BUILT UPON? WHERE ARE THE MAIN CHALLENGES AND GAPS? WHO IS BEING LEFT BEHIND AND WHY?

"Data is showing us that we have an historic opportunity to end the epidemic, that we have to better focus our investments and programmes, global and regional responses needs to be accelerated as the widow we have is limited in time."

Consultation participant

Achievements of the AIDS response

- Human rights focus in prevention, care, treatment approach to key populations
- Demonstrating how harm reduction works – when it is done well and when policy allows
- The early days of the region's response saw important success in prevention approaches among men who have sex with men

- Expansion of testing and treatment uptake – including rapid testing in communities in non-medical settings (only four countries though allow HIV testing in non-medical setting – in the majority, state supervision is required in community service delivery settings)
- Focused interventions for specific populations at highest risk – proven to work well when delivered by communities, however, the region has not seen the same levels of attention and success in this area for sex worker and transgender populations as has been seen with other populations.
- Good data reporting from Member States, including community-driven evidence
- Good collaboration between communities of civil society organizations and state health systems
- Strong social security systems, social protection programmes
- Ongoing political and financial commitment – both domestic and international

Challenges, gaps and global and regional developments that could impact the region's epidemic and response

"The World is changing, sometimes we are not moving fast enough with it."
Consultation participant

Broader political landscape: 2015 is a key year of intergovernmental deliberations leading to SDGs. Much more complex and crowded SDG environment—only one of 169 targets is on AIDS— and there is a need to keep HIV high on the political agenda. This is a challenge but also an opportunity as there are many areas within the SDG framework that directly link to the AIDS response – eg, access to SRHR, gender equality goal – addressing discriminatory laws. Greater integration is key. We need to be mindful that while the universal health coverage agenda provides a framework for HIV, it does not adequately address the needs of key populations or SRHR of women and young people.

Complacency: In recent years there has been decreased interest in HIV and related topics – lost interest of health decision makers, politicians. Implications include decreased allocation of financial resourcing, policy reforms and systemic changes. We are not seeing the regional community lobby as much as it used to. There is a need to look at how to mobilize community voices and actions.

Increasing conservatism: We are seeing a growing political and social conservatism in some spheres threatening hard-won achievements in human rights. Growing trends of conservative pushback and heterogeneous positions are a reality, particularly around legal environments for sex work, drug use and migration. Access to comprehensive sexuality education for adolescents remains largely theoretical for a significant part of the adolescent population of the region. There is anxiety among decision makers on sexuality education for young people.

Changing epidemic trends: The drivers of vulnerability to HIV are changing in the region, as much as the response is changing. For example, there have been shifts in drug use from injecting to non-injectable substances among drug user populations, and increasing recreational injecting drug use among gay men. Beyond who uses drugs and how, the way drugs enter and are distributed in the region and globally are also shifting.

Testing: Despite regional success to increased access to testing and treatment, still not enough people are coming to testing early enough. Late diagnosis is a reality across the region, even in the highest-income countries. Testing remains the key barrier to reaching 90-90-90 in the region. Low access to testing for and reaching marginalized populations through state medical facilities is a significant obstacle.

Inequalities: Not every country in the region is experiencing the same economic growth or stability. Moreover, not every country in the region is equally meeting the needs of people living with HIV and other key population groups at risk.

Pricing: Prices for treatment are too high even for a region considered to be rich – current and non-competitive pricing of treatment for HIV, HepC and other co-morbidities and co-infections is becoming an increasing concern as the population to be treated is rising due to life prolonging treatment. To reach 90-90-90 unlocking pricing barriers is critical to financial sustainability in the AIDS response.

Migration: Migration is a crucial issue for the region. Migrants still disproportionally represent new HIV infections in Europe – up to 1/3. In parallel, Western Europe is experiencing a new type of migration – greater mobility within Europe, as well as greater influx of migration. We need to think about what happens to people once they are within the region and how access to social services including health can occur irrespective of someone's nationality or ethnic origin.

Stigma and self-stigma: As for all regions, pervading stigma and discrimination continue to be a barrier to access to services and reaching key populations at highest risk. In Western Europe, it was remarked that self-stigma within communities for those living with HIV is particularly significant. Additionally, stigma of those living with HIV within their own population groups needs greater attention and appropriate response.

2. IN ORDER TO REACH THE FAST-TRACK TARGETS, WHAT SHOULD BE THE REGION'S STRATEGIC PRIORITIES IN THE RESPONSE?

- Testing and linkage to treatment – a shift is needed to ensure more acceptable, accessible and appropriate testing approaches for all key populations living with HIV, in particular population groups that are greater risk and marginalised.
- Scale up and innovate combination prevention tailored for each key population, and including harm reduction, comprehensive sexuality education and in and out of school programmes. Opportunities offered by new technologies such as PrEP need to be utilised and incorporated into national HIV strategies.
- Integration of HIV services with other health and social services, that normalize and take HIV out of isolation. Ensuring HIV prevention, treatment and care are integrated into general primary health will help the response to HIV to become more sustainable while utilising synergies.
- Innovative approaches need to be recognised, documented, disseminated and replicated. The regional response needs to move from the WHAT to the HOW, learning from other success within and beyond the region.

> *"We need to change the way we work, and we can learn from other regions as much as we can share with other regions."*
> Consultation participant

- Understand and respond to inequalities – within and across countries in the region.
- Promote non-discrimination and quality of services in health care settings.
- Reduce prices of treatment for HIV, HepC, and other co-infections and comorbidities.(Re)mobilise communities to demand services, know their rights, be active participants in the response. Empower communities to reach their constituents, but also enable communities to claim ownership of the issue as well as the response. In particular, empower young people from key population groups to be agents of change in

the scale up of prevention, testing, treatment and reduction of stigma.

> *"Hard to reach is hard to reach if you are not reaching people the right way."*
> Consultation participant

- Improve data, including through community participatory research.
- Address legal and policy environment – enact protective laws, reform punitive laws, promote access to justice and fair law enforcement, and remove structural barriers that prevent access to services for vulnerable populations.
- Address shifting and broader political environment and mobilise political will. States need to take responsibility to provide services and care for the vulnerable.

3. WHAT WILL NEED TO CHANGE IN SUPPORT OF THOSE PRIORITIES? WHAT ARE THE "GAME-CHANGERS" – IN TERMS OF POLICY AND LAW REFORM, FUNDING, RESOURCE ALLOCATION, PARTNERSHIPS, SERVICE DELIVERY, EMPOWERING CIVIL SOCIETY, SCIENCE AND INNOVATION, AND LINKS WITH OTHER HEALTH AND DEVELOPMENT EFFORTS?

- Strategic use of ARVS: Treatment saves lives and prevents new infections. This narrative needs to be better told and utilised for HIV-positive and HIV-negative people – the preventive benefits of treatment for people living with HIV, the preventive benefits on people accessing PrEP.
- Stop the "HIV second silence" in Western Europe: Governments, civil society, and communities at large have stopped talking about HIV (AIDS response fatigue, perception that HIV is no longer a threat). At the same time within communities competing priority issues of rights and equality take precedence within a framework of limited resources and capacity.
- Moving from HIV stigma measurement to key population stigma reduction
  - HIV-related stigma reduction efforts to date have been limited to raising awareness of modes of transmission and prevention, and the rights of those living with HIV. In a region where people living with HIV and new infections are largely among key marginalized population groups, HIV-stigma reduction needs a shift in approach to focus on homophobia, xenophobia, transphobia, discrimination faced by people who use drugs and sex workers. Issues of discrimination towards people living with HIV within their own key population groups also need to be given focus in programming.
  - Stigma reduction efforts can build community resilience, can mobilise communities and drive change at a societal level. Comprehensive sexuality education offers a significant opportunity for stigma reduction as well as empowerment of young people.
- Pricing: A price reduction strategy for treatment, equipment and diagnostics that result in a financially sustainable response in collaboration with the private sector.
- Maximize impact of meaningful youth involvement: Young people are a valuable partner, in particular young key populations. Young people represent the next generation of the AIDS response as much as they represent the next generation of our societies.
- Technology and connectivity: Better use of technology for a more effective and efficient response to raise awareness, to mobilise communities, and to provide strategic information. Use of technology also affects and impacts behaviour and access to services.
- Utilize the political opportunities of the Sustainable Development Goals
  - SDG framework will shape how the global community responds to development issues, including HIV. The framework provides an opportunity to ensure that actions to reduce and eliminate human rights violations, gender inequality, poverty, discrimination on the base of sexual orientation, drug use or profession – the

underlying factors of vulnerability to HIV – work together with the AIDS response to end the AIDS epidemic by 2030.
- UNAIDS has a key role to mobilise political will and facilitate exchange of knowledge on how to 'get to zero' while getting to SDGs.
- Governments of Western Europe need to continue to show leadership.

4. WHAT ARE THE MOST CRITICAL WAYS IN WHICH THE UNAIDS JOINT PROGRAMME CAN SUPPORT EFFORTS IN THE REGION TO END AIDS AS A PUBLIC HEALTH THREAT BY 2030?

- New narrative: UNAIDS is recognized by the region as the global leader to drive the new narrative on the AIDS response. The AIDS response is complex; the UNAIDS Strategy can articulate a response that is complex but not complicated.
- Continue to be bold: UNAIDS can take on difficult and controversial issues, address conservatism. UNAIDS must not shy away from these difficult issues. Continue being the global advocate for AIDS and other development topics – SRHR, the rights of marginalized and vulnerable populations. Critical UNAIDS voice to shift the paradigm, and promote exchange within and between regions
- Lead on evidence and expert guidance: UNAIDS continues to be the go-to place and partner for strategic information on the HIV epidemic and response. It is trusted and respected – greater granularity of data, focusing on people left behind, is welcomed. The Joint Programme must also continue to provide guidance on emerging issues, scientific breakthroughs and service delivery good practice and innovation.
- Revive media / public interest: UNAIDS needs to help recapture media attention on HIV – what impact it has on people, communities, on key populations – make HIV visible again, in every country and globally. Working with leaders, including mayors, politicians, community representatives, is important.
- A true partner to communities: UNAIDS has demonstrated exemplary work on how it engages with civil society. We need UNAIDS to step up support and mobilise more support to community organizations, especially where governments are not providing services for marginalized communities.
- Coordinating and convening: UNAIDS to continue playing its coordinating and convening role – and to continue to encourage its cosponsors to organize their work and funds around UBRAF. UNAIDS voice is critical to shift the paradigm, and promote exchange within and between regions. UNAIDS should be the broker between governments and civil society – national and regional bodies – in post-2015 agenda.
- Inspire political leadership: UNAIDS needs to keep engaging with political leaders to implement responses that are evidence-informed, human rights-based, culturally appropriate, age specific and gender-responsive.
- Continue to promote Fast Track and the investment framework: Fast Track approach provides strong vision and provides a good background and guide strategic investments. Use and ensure the strategic investment framework is APPLIED – the comprehensiveness of the AIDS response – critical enablers, development synergies as key to ending the AIDS epidemic as a public health threat.

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Discussion note
Regional Consultation on UNAIDS Strategy 2016-2021:

EASTERN EUROPE AND CENTRAL ASIA (EECA)

9 April 2015, Minsk, Belarus

KEY MESSAGES ON UNAIDS STRATEGY

- **High-level political will** is key to achieving any breakthrough in the AIDS response across the region of EECA, including to fast-track HIV prevention, treatment and care, and to mobilize sustainable domestic financing.
- In order to **create enabling legal environments for the AIDS response,** conservative / restrictive laws that create and punish vulnerability (e.g. bans on 'gay propaganda', criminalization of risky behaviour) must be reformed, legal barriers to services eliminated and stigma and discrimination addressed.
- Given that the HIV epidemic in the region is concentrated among IDUs, it is considered urgent to **introduce and/or scale-up the coverage of harm reduction programs** (including needle exchange and opioid substitution therapy) that protect and promote human rights, based on a public health approach.
- Significant progress has been made towards the elimination of new HIV infections among children in the EECA region; **HIV treatment must be dramatically scaled-up for everyone living with HIV,** however, with a focus on key populations, who continue to face significant barriers to access treatment. Reducing the cost of ARVs and decentralizing the provision of treatment will be critical to scale-up.
- **Capacity of communities and civil society** must be strengthened to advocate for and partner in the delivery of HIV prevention, treatment, accountability, and help to ensure the scale-up and sustainability of services and programmes.
- UNAIDS plays a **critical advocacy role** globally and regionally, and should redouble its efforts in the region to increase political will for rights-based, evidence-informed responses and an enabling legal environment, as well as enhance its provision of technical support for implementation.

EXECUTIVE SUMMARY

The Joint United Nations Programme on HIV/AIDS (UNAIDS), in partnership with the Ministry of Health, and Foreign Affairs of the Republic of Belarus organized regional consultation meeting in Minsk, Belarus on 9 April, 2015 to discuss and gather recommendations to update and extend the UNAIDS Strategy for the period from 2016 to 2021. The meeting served as a formal consultation on regional priorities for EECA and overall what needs to be done differently in the AIDS response post-2015 to achieve our ambitious aims for 2021.

The meeting participants included 57 representatives from 13 countries of the region, including from governments, civil society organizations (3 of whom are PCB NGO delegates) and networks of people living with HIV from across the region, as well as scientific experts, and representatives of the UNAIDS Joint Programme (ILO, UNDP, UNFPA, UNICEF, UNODC, UNODC, WHO and the UNAIDS Secretariat). UNAIDS Regional Goodwill Ambassador Vera Brezhneva attended a session and shared her input, drawn from her consultations with representatives of key populations.

Participants agreed that some of the countries in the region (e.g. Belarus and Ukraine) have championed the AIDS response and made significant progress, while other countries, such as the Russian Federation, continue to provide the majority of resources for AIDS, both domestically and as a regional donor. They further agreed that there is major potential for all the countries in the region to rapidly scale-up results and use a 'fast-track' approach to advance the end of AIDS as a public health threat. However, progress continues to be held back by a range of key obstacles, including: a lack of political will and commitment; prevailing social stigma and discrimination against some key populations (e.g. people who inject drugs and men who have sex with men); resistance to implement evidence-informed methods (e.g. harm reduction); legal environments that may promote discrimination of key populations; and insufficient financial resources.

> *"The Strategy should include the importance of working with opinion leaders, so that they can pass on to the people under their influence that it is important to respect representatives of all groups of society, including key populations."*
> Chinara Bakirova, Executive Director of the Anti-AIDS Association, Kyrgyzstan

Participants urged that the updated UNAIDS Strategy take into account regional specificities, strengthen UNAIDS advocacy role with governments and civil society, promote people-centred, human rights based approaches for effective HIV responses in the region, and both inspire and guide countries in pursuing effective cross-sectoral cooperation.

FIVE CONSULTATION QUESTIONS: DISCUSSION SUMMARY

1. HOW WILL DEVELOPMENTS – GLOBALLY AND IN THE REGION – IMPACT THE EPIDEMIC AND RESPONSE IN THE REGION, SUB-REGIONS AND SPECIFIC COUNTRIES OVER THE NEXT SIX YEARS?

Globally:
- The global AIDS architecture is in transition: e.g. 3 out of 8 MDGs were related to health, one was specifically on HIV. However, with transition to the Sustainable Development Goals (SDGs), HIV is placed under the health goal – which is only one of 17 SDGs . This could be considered a threat, but should be embraced as an opportunity to embed HIV within broader health and other thematic areas as a crosscutting issue.
- Champion countries (Brazil, South Africa) lead the way using innovative methods to fast-track their response to the HIV epidemic (community-based testing, express-tests, use of generic drugs, etc), demonstrating strong hope that ending AIDS by 2030 is possible, but much work needs to be done to promote the use of these approaches in EECA.

In EECA region:
- The number of new HIV cases is on the rise.
- The region is not homogenous, which means the Strategy should be adjusted for different countries based on their specificities.
- Politically, the region is divided between two different political aspirations: countries who are members of or are leaning towards the European Union, and other countries that are members of the Eurasian Economic Union or the Commonwealth of Independent States.
- The conflict in Eastern Ukraine has deteriorated the situation in the whole region. Energy-dependent economies are facing an severe economic downturn. Economic protectionism is on the rise, with several countries pursuing import substitution, which could impede competition and lead to higher prices.
- Prices for ARVs and the unit cost of many other services remain high. The Global Fund to Fight AIDS, Tuberculosis, and Malaria (GFATM) is likely to significantly decrease its support for the region. With the exception of limited donor funding from the Russian

Federation and the European Union, the majority of countries do not have access to external grants to scale-up their AIDS response. With the exception of Kazakhstan, national governments in the region have yet to commit to significantly increase funding for health, development, and HIV.
- Systemic issues contribute to high ART drug prices: in some countries the prices of brand or generic ART drugs are equally high, and the low level of ART coverage provides limited incentives for pharmaceutical firms to explore this region as a growth market.
- Migration both inter-countries and within countries contribute to the spread of the HIV epidemic.
- Stigma and discrimination of key populations remains high: knowing HIV status is putting them under threat, both legally and socially. Such threat may be a major disincentive to access HIV testing.

In specific countries:
- The influence of religion is on the rise and is used as a tool to support conservative laws by policy makers, particularly in some countries in Central Asia.
- A new wave of conservative laws are limiting the rights of individuals to access HIV services, including key populations (such as sexual diversity, fuelling a hidden epidemic among MSM).
- A new alarming trend of IDU-driven HIV epidemic on the rise (e.g. Belarus, Russian Federation), against which innovative and efficient response mechanisms are needed for effective results.

2. WHAT ACHIEVEMENTS OF THE REGIONAL RESPONSE SHOULD BE EXPANDED AND BUILT UPON? WHERE ARE THE MAIN CHALLENGES AND GAPS? WHO IS BEING LEFT BEHIND AND WHY?

Achievements:
- Access to treatment of paediatric HIV (more than 60% access) in the region.
- Significant progress towards EMTCT (in some countries it can be virtually eliminated soon, e.g. Armenia, Belarus).
- Strong and vibrant civil society organizations in many countries of the region have played important role in advocating for and delivering HIV prevention, care and support programs. NGOs have a critical role and potential capacity to promote HIV testing amongst key populations.
- Positive examples of collaboration between civil society and government in some countries. e.g. in Ukraine, achievements thanks to targeted efforts by government and civil society to decrease new cases among adolescents and young IDUs.
- Several countries have rolled out large HIV treatment programmes. At the beginning of 2015, over 185,000 people were on treatment in the Russian Federation. Ukraine increased access to treatment 3–fold during the last 3 years to over 68,000 people on treatment at the beginning of 2015. These are significant achievements and should be built upon.
- In 2014, Ukraine adopted a new law on efficient procurement of services from the public budget and involvement of international organizations in the procurement processes.
- AIDS response structure in EECA is strong and should be further strengthened (e.g. AIDS Centers), providing widespread access to HIV testing and extensive epidemiological data
- Harm reduction programmes, particularly needle/syringe and opioid substitution therapy programmes, have been successfully implemented to scale in some countries (e.g. Czech Republic, Estonia, Moldova, Ukraine). Syringe replacement and substitute therapy programmes in Armenia, Uzbekistan, Tajikistan, are examples of good

programmes that have been successfully implemented, but are limited to external (Global Fund) funding.
- The region has experience in scaling up services for key populations, which are often socially marginalized. Such experience can be shared with other regions.
- 85% of HIV epidemic burden is concentrated in two countries - the Russian Federation and Ukraine, so we know where efforts must be focused.

Challenges and gaps:
- The lack of political will for a breakthrough in the HIV response remains one of the most critical challenges.
- The high cost of ART in most of the countries limits treatment scale up. High costs are partly a result of lack of capacity of local governments in international procurement procedures, and the low level of coverage / size of market.
- While children increasingly have good access to HIV treatment, their mothers often do not – driven by stigma against infected adults. In some countries, 5% of pregnant women living with HIV do not come to medical facilities for ART, and give birth at home. Stigma and other challenges significantly impact adherence as well.
- In general, for a range of reasons, many people continue to face significant challenges in accessing services; therefore many people still remain out of the reach of the medical system.
- There is a need to assess the shortcomings related to the provision of services, including the lack of trust among people living with HIV towards healthcare institutions, and the availability and capacity of the skilled medical professionals to provide needed services.
- There are differences in service availability and quality within the EECA region between countries and among different areas within countries. Vulnerable subregions need to be supported to address the lack of infrastructure and skilled healthcare workers in field medical facilities, which is important for decentralization of the HIV services.
- Cooperation between different sectors is lacking or insufficient (e.g. medical institutions and the police). Legal barriers to services for migrants, for example, are mainly due to the lack of coordination among different (government) sectors.
- Civil society organizations face significant limitations in how they can influence policy-making related to HIV services.
- Harm reduction programs, particularly needle syringe and opioid substitution therapy programmes, have not been implemented to scale in the majority of EECA countries. It is critical to ensure such programmes are informed by human rights, and that they are linked to services for related conditions (e.g. 56% of IDUs in EECA have either Hepatitis C or TB). Pre-Exposure Prophylaxis (PrEP) should be included in public health programmes.
- Social and structural discrimination exists against key population, e.g. injecting drug users and MSM. Legal improvements do not always translate into concrete actions.
- Large international financing organizations should monitor and encourage progress not only from a financial accountability standpoint, but also in terms of promoting an evidence-informed and human rights-based programmatic approach, in working both with government and civil society organizations.
- Low knowledge of the fact that many HIV services are funded by external sources, and lack of preparedness of national governments to take over the funding using national budgets. EECA countries should become more active to reflect their needs and interests in the governance of the Global Fund, particularly as it updates its strategy.
- Lack of information and public awareness programs promoting healthy lifestyles (e.g. drug abuse, alcohol abuse) and reducing stigma and discrimination related to HIV.

3. **IN ORDER TO REACH THE FAST-TRACK TARGETS, WHAT SHOULD THE REGION'S STRATEGIC PRIORITIES BE IN THE AIDS RESPONSE?**

-   Extend **best practices of champion countries** in the region (e.g. Belarus), and globally (e.g. Brazil, South Africa) to other countries in the region.
-   Mobilize **political commitment** to the AIDS response at the highest level in the context of public health, human rights, and healthy lifestyle (not only about HIV, but in the context of all health issues).
-   Work with political leaders across sectors who influence the development of strategically important policies, such as harm reduction and funding for HIV programmes. Opinion leaders, including religious leaders, will also be influential in reducing stigma and discrimination against key populations. Strategic political advocacy should demonstrate how HIV is central to creating inclusive societies and other development priorities.
-   Create full-fledged, **equal partnerships** between the government and non-governmental organizations, using e.g. social contracting. It has yet to be operationalized as intended.
-   Ensure sustainable financing of national HIV responses and promote more efficient distribution of government funds, guided by **evidence-informed policies**, particularly as countries transition to national funding sources.
-   Promote **community-based testing** focused on reaching key populations. Provider-initiated routine HIV testing and counselling approaches should be adapted at primary, secondary healthcare settings. In general, the capacity of medical professionals must be strengthened for better service provision of HIV testing and treatment, as the current infrastructure is inadequate to reach everyone with HIV.
-   Rapid scale up in HIV testing will be critical to increasing treatment coverage, as will **reducing the cost of ARVs** (by e.g. bulk-buying, offering fixed-dose regimens as 1st line therapy, moving away from individual treatment regimens). Efforts must be made to ensure the quality of ART drugs is not compromised.
-   The HIV response must reflect that AIDS is not only a medical issue, but a human rights issue. The response should be 'people-centred' – prioritizing the engagement of key populations in the response, implementing a gender equality approach in HIV programming, integrating prevention services with those for other health services, ensuring migrants have access to services where they are located, with a view to **reforming the legal environment** and ultimately eliminating discrimination.
-   Technological innovations provide opportunities for creating **public awareness and social mobilization**. Social media tools (twitter, Facebook) should be used more as efficient tools to spread what works well.

4. **WHAT WILL NEED TO CHANGE IN SUPPORT OF THOSE PRIORITIES? WHAT ARE THE "GAME-CHANGERS" – IN TERMS OF POLICY AND LAW REFORM, FUNDING, RESOURCE ALLOCATION, PARTNERSHIPS, SERVICE DELIVERY, EMPOWERING CIVIL SOCIETY, SCIENCE AND INNOVATION, AND LINKS WITH OTHER HEALTH AND DEVELOPMENT EFFORTS?**

-   Clarify, finance and expand the role of civil society. Government instruments should be adopted that specifically regulate and support activities of the NGOs in the field of HIV. Increase the role of NGOs in HIV testing, with government funding and legal regulations. Reduce / wave fees for NGOs to get licensed to provide for HIV testing. Improve legal frameworks and financing for social contracting of NGOs. Establish public-private partnerships, in addition to social contracting with NGOs.
-   Scale up domestic resources. Work with governments to develop sustainability transition plans that will increase national investment in the HIV response for each coming year and develop a clear roadmap for managing the decrease in international investment. Introduce taxation and innovative financing mechanisms to the HIV response, e.g. on luxury products, plane tickets, alcohol, tobacco, currency transfers.

- Involve ministries of finance and economics as key partners in formulating national HIV strategy and action plans, to ensure programmes are economically efficient and linked to the national plans for socio-economic development.
- Expand HIV testing. Make mobile testing and rapid tests widely available, including at pharmacies. Guarantee access to rapid HIV treatment for those that access HIV testing. Reform laws to enable NGOs to administer HIV tests.
- Revoke bans on 'gay propaganda', and other restrictive legislation that create and punish vulnerability (e.g. criminalization of behaviours or legal barriers to services), and introduce anti-discriminatory laws.
- Use TRIPS public health flexibilities, avoid and mitigate TRIPS-plus provisions, allow direct international procurement, and/or increase local production to reduce cost of ART medicines.
- Introduce earmarked funding for gender equality programmes.
- Offer HIV testing and treatment for migrants both in origin and destination countries, given that migration is significant in the region between countries and within countries (e.g. Russia). Promote cooperation within Eurasian Economic Union to include HIV in the medical services provided to citizens of the member states.
- Decentralize ART delivery efforts to district levels (not to village levels).

5. WHAT ARE THE MOST CRITICAL WAYS IN WHICH THE UNAIDS JOINT PROGRAMME CAN SUPPORT EFFORTS IN THE REGION TO END AIDS AS A PUBLIC HEALTH THREAT BY 2030?

- UNAIDS Strategy should be bold and ambitious, and put responsibility on all stakeholders (government, civil society, private sector). The new UNAIDS Strategy should serve as an inspiration for countries to promote cross-sectoral cooperation and fast-track progress.
- UNAIDS plays a critical advocacy role globally, regionally and nationally. UNAIDS should use its new Strategy to redouble political advocacy efforts in the region to increase political support for a rights-based, evidence-informed response to AIDS and promote an enabling legal environment.
- UNAIDS should exercise its leadership to find financing solutions in the region including by convening a dialogue with national governments for increasing domestic financing (sustainability transition plans) and with international donors (Global Fund) to not retreat fully. Furthermore, UNAIDS should work more closely with governments in developing mechanisms to guide and monitor efficient spending in order to provide incentives to fast-track progress to end the epidemic in the region.
- UNAIDS should work as ONE. Each UNAIDS cosponsor should have HIV clearly featured in their regional and country workplans.
- UNAIDS should strengthen its political advocacy and technical support role. UNAIDS should actively reorient national governments and their national AIDS programmes to reach 90-90-90 targets by 2020 and the end of AIDS by 2030.

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The Joint Programme was represented by ILO, UNDP, UNFPA, UNICEF, UNODC, WHO and the UNAIDS Secretariat

Discussion note
Consultation on the UNAIDS Strategy 2016-2021:

VIRTUAL CONSULTATION

23 March – 2 April 2015

KEY MESSAGES FOR UNAIDS STRATEGY

- Accelerating **reduction in new infections** will rely on stronger strategic information on risk and vulnerability, scaled up combination prevention programmes focused on populations at high risk as well as innovation in science and service delivery.
- Rapidly **scaling up HIV treatment access** will rely on community-based services, including point-of-care diagnostics and viral load monitoring, smart integration with health and social services to address holistic needs and national, regional and global collaboration to reduce the cost of ARVs.
- In different settings, a range of **vulnerable populations continue to be left behind** – these include men who have sex with men, sex workers, people who inject drugs, transgender people, women and girls, adolescents and young people, children, older people, migrants, refugees, internally displaced people, people with disabilities, prisoners, ethnic minorities and indigenous populations. Focused efforts must be made to reach these populations and include them in the governance of the response.
- **Stigma, including self-stigma, and discrimination** faced by people living with HIV must be addressed through a range of social, legal, political and community interventions in partnership with health professionals, faith-based leaders, the police and the media, among others.
- **Young people demand better access to sexual health information and education** – and in the face of continued obstacles to school-based sexuality education, support is needed for youth-led community and online platforms that provide information, support and advocacy strategies.
- **Scaled-up and long-term support for civil society** is critical to rapidly expanding and sustaining the AIDS response. UNAIDS must more forcefully protect the role of NGOs in policy design, implementation, evaluation and activism – even in the face of opposition from governments.
- **Sustainable and diversified investments** will be critical to scaling up the response and ensuring that essential programmes for key populations are adequately funded.
- **UNAIDS should strengthen its role** in mobilizing diversified and sustainable investments, focusing resources on high impact countries, ensuring national costed evidence-informed strategies, generating political pressure to implement those plans, and pursuing smart programmatic integration.

EXECUTIVE SUMMARY AND CONSULTATION METHODS

The first of two global virtual consultations on developing the UNAIDS Strategy was held from 23 March through 2 April. The overall aim was to encourage open and interactive discussion including with stakeholders who might otherwise not be reached through in-person consultations.

The virtual consultation generated a lively debate with over 280 inputs submitted by participants from 50 countries in 5 languages. Thirty additional inputs from organizations were submitted directly to the UNAIDS Strategy Development email. The structure of the virtual consultation was centred around four themes, "Reinforcing achievements", "Closing

the gaps", "Seizing the 'game changers'" and the "Youth Forum", thus the structure of this report varies slightly from other consultation reports. Each discussion ran in parallel, and was overseen and evaluated on a twice-weekly basis by a moderator. The consultation was particularly successful in generating high-quality and meaningful inputs from people living with HIV, members of key populations and young people.

Active outreach through the use of various listserves relating to HIV and human rights, gender, governance, faith and youth helped boost the quantity and breadth of inputs. Moreover, UNAIDS regional offices and Headquarters staff informed networks with whom they collaborate and a communication was sent out to the Programme Coordinating Board listserve. Social media was also employed to publicize the consultation with organized Twitter activity by UNAIDS leadership including the Executive Director and Deputy Executive Directors as well as UNAIDS Goodwill Ambassadors. The UNAIDS website and Facebook page were also employed to communicate on the consultation.

CONSULTATION QUESTIONS: DISCUSSION SUMMARY

"I am relieved to find a virtual space, without constraints, that allows us to speak freely about the challenge of HIV."
Consultation participant

1. WHAT ACHIEVEMENTS OF THE GLOBAL RESPONSE SHOULD BE EXPANDED AND BUILT UPON?

Principle and practice of Greater involvement of people living with HIV (GIPA)

GIPA has been particularly effective in driving a rights-based AIDS response, but is in need of renewal. Participants emphasized that community involvement must not be considered simply as an add-on for reasons of representation, but that the activism, policy design, service delivery, and M&E role played by communities ensures that programmes are relevant and accessible to the people who need them most. Community involvement is further critical in collecting data on "hidden" populations, such as displaced people, refuges, immigrants and indigenous peoples.

Concern was raised that the "professionalization and industrialization of the HIV response" had resulted in the exclusion of many lay people living with HIV and other community representatives from the governance of the response. Furthermore, diminishing funds for civil society in many places has forced organizations to have to downsize or close, and created a culture of competition rather than collaboration.

In the case for example of Western and Central Europe, reinforcing GIPA will be critical to addressing rising HIV infection rates among MSM – apparent in a number of countries including those that meet a high standard of services. Participants contend that community leadership will be critical to incentivizing high-risk populations to proactively monitor their sexual health, including HIV testing and viral load monitoring, as well as innovative new prevention methods such as PrEP.

"When community is involved in research, better medications are produced. When we are involved in policy, we can change perceptions. When we are engaged in testing, we have better results in early diagnosis. Now it is time for the gap between the scientific community, policy makers and activists to close in order to become cost-effective and successful."
Consultation participant

Community leadership of combination prevention

Evidence-informed and rights-based prevention conceptual frameworks, including combination prevention and Positive Health, Dignity and Prevention, have propelled important progress in both preventing new HIV infections and exposing the multisectorality of HIV vulnerability. Participants saw that community leadership had played a central role in implementing combination prevention, and urged that the core package of male and female condoms, male circumcision, STI services and HIV education not be sidelined by newer technologies. Participants reminded UNAIDS that such leadership on combination prevention would be key to progress on all goals, including 90-90-90.

Prevention of HIV infections in children

Success in preventing new infections among children and in reaching mothers with treatment for their own health across all regions must continue to be built upon. EMTCT programmes have further enabled women to be linked to broader health services including for ante- and post-natal care and sexual and reproductive health. However, the risk of HIV transmission during the pregnancy and delivery periods has been reduced, the risk of HIV transmission is now concentrated during the breastfeeding period. More rapid roll-out of recommended Option B or B+ regimen policies, as well as support to retain mothers in care are needed in order to ensure that children can breastfeed safely.

Participants recognized the significant impact that high-profile leadership had made in rapidly scaling up efforts to prevent new HIV infections among children. Participants called for similar political leadership in more controversial areas including access to services for key populations.

Harm reduction

Harm reduction has been highly effective in reducing new HIV infections. Harm reduction programmes have developed trust and rapport between the health system and people who use drugs that can lead to prevention, treatment and support for marginalized and often criminalized populations. Some faith-based approaches espouse harm reduction in their HIV work and this has proven particularly effective in promoting outreach and community acceptance.

Access to antiretrovirals

Unprecedented results have been achieved in extending coverage of ARVs in most countries. Today the big task is how to reach those people who still do not know their status, particularly the socially marginalized. Extended availability of rapid testing, access to user-friendly health services and policy changes in many countries will be key.

HIV-related legal services

Much has been learned through the scale up of HIV-related legal services for people living with HIV and other key affected populations. Yet the policy loop must be closed – through the experience of delivering legal services, the response must learn what is needed in terms of policy and law reform. There is also an opportunity to address a range of social justice issues through strengthening legal education in order to equip lawyers and future leaders to address the socio-economic determinants of HIV, and health more broadly.

Multisectoral approach

Participants recognized that the cross-sectoral nature of the AIDS response has been critical, and recognized that the UNAIDS Joint Programme had played a central role in this aspect. Participants pressed UNAIDS to continue to promote attention to the socio-economic structural drivers of HIV in order to address the underlying causes of vulnerability and marginalization.

2. WHERE ARE THE MAIN CHALLENGES AND GAPS? WHO IS BEING LEFT BEHIND AND WHY?

"If people aren't safe, if they don't feel like they deserve to live or thrive, then science will leave so many behind."

Consultation participant

Stigma, discrimination and violence against people living with HIV

Stigma against people living with HIV, including self-stigma, remains a pervasive challenge. Research and interventions to reduce self-stigma is a particularly glaring gap. Stigma inhibits people from getting tested and silences people with HIV from talking about their status. In many regions, exposing one's HIV status may also result in being exposed as a man who has sex with men, a person who uses drugs or a sex worker – with often severe legal and social consequences. Children of people living with HIV and other key populations, regardless of their own HIV status, also experience severe stigma. Stigmatizing behavior on the part of health workers can further deter people from accessing services.

Unequal status of women in society and inadequate participation in the AIDS response

The AIDS response has not been able to effectively counter gender inequality, harmful stereotypes and patriarchical values, which continue to place young girls and women at risk. Effective prevention programmes in high prevalence settings receive inadequate support – particularly those addressing multiple concurrent partnerships and gender-based violence. Poverty remains a major determinant of vulnerability particularly for women. The specific barriers faced by women living with HIV in accessing HIV treatment and SRHR services must be overcome. Treatment and human rights literacy among women living with HIV is low in many places and women are not engaged in research and clinical trials.

"We cannot focus on vulnerable populations without addressing people in positions of power who reinforce inequalities. HIV and gender equalities continue to place a significant constraint on the advancement of women and girls and impact women's health and well-being."

Consultation participant

Inaccessibility of sexual and reproductive health information and services for young people

Adolescents and young people demand much greater attention in the response, including in areas of comprehensive sexuality education, employment, self-esteem, risk reduction and 'voice' in general. Several participants saw the classification of sex and sexual diversity as taboo subjects as a major impediment to empowering young people to make informed decisions about their health and sexuality. Beyond social constraints, legal restrictions such as parental and spousal consent laws also keep young people – particularly young women – from accessing sexual and reproductive health information and services.

Ongoing, and sometimes expanding, criminalization of drug use, sex work and sexual diversity

Many participants expressed growing concern in the face of a wave of new legislations that run counter to an enabling legal environment for the AIDS response, such as those that criminalize same-sex behavior, drug use and HIV transmission and undermine the rights of transgender people. Over-criminalisation leads to social exclusion and vulnerability, and results in failure to provide evidence-based services. Furthermore, such criminalization is linked to an often-total absence of domestic funding for HIV prevention among most-at-risk populations.

> *"If we can not talk openly about capitalism, patriarchy, religious fundamentalism, colonization and the plethora of other issues that drives the epidemic then we will be unable to move forward in ways that will be transformative."*
> Consultation participant

Marginalization and disempowerment of specific groups and communities

Ethnic minorities, particularly people of African descent
Despite being identified as one of the first key populations at the start of the epidemic, racialized populations and their vulnerabilities to HIV have not been adequately incorporated into mainstream responses. Inequality is further driven by a 'triad of discrimination' many racialized populations face based on HIV status; ethnicity; and migrant status.

Indigenous populations
Indigenous people face systemic and institutionalised racism. Indigenous people have and still face continued genocidal behavior from governments, with poor health outcomes and low socio-economic realities. As a consequence, trust of health professionals and services is low. HIV further adds layers of stigma and discrimination to the indigenous experience.

People living with disabilities
People with physical, sensory, psychosocial, and intellectual disabilities may be more vulnerable to HIV infection due to lower education and literacy levels, greater poverty, and greater risks of physical and sexual abuse. Discrimination within the family, admission barriers, and lack of physical accessibility keep many children with disabilities out of school, where they might access HIV information.

Older people living with HIV and providing care
There is a major gap in reaching older people living with or at risk of HIV. Older women's issues are particularly unattended, both in terms of the burden of disease and the burden of care giving. Little research has been undertaken on HIV and ageing.

Migrants
Immigration laws, detention and deportation policies, refugee and asylum conditions, and unequal rights for undocumented migrants often serve to make migrants more vulnerable to HIV, poor health and social injustice. The lack of services and representation for migrants with and vulnerable to HIV is profound, even among civil society organizations.

Pediatric ART

Participants highlighted the need for child-specific and child-friendly point-of-care diagnostics and ART regimens, and stronger monitoring of how these services are delivered, to address the unacceptably low coverage of children living with HIV on treatment as well as the high rates of treatment interruption and loss to follow-up.

3. **IN ORDER TO REACH THE FAST-TRACK TARGETS, WHAT SHOULD THE STRATEGIC PRIORITIES BE IN THE RESPONSE?**

a) **Focused, effective prevention programmes tailored to population needs:** User-friendly, rights-based services must be available to the people who need them (legally and geographically – rural and urban) – as part of a national framework that optimizes investments. Indigenous people, migrants, refugees, internally-displaced persons and people with disabilities must be recognized as key populations, and targeted services be made available to them. Psychosocial support and building healthy relationships between men and women and girls and boys is critical to prevention. Strong progress towards eliminating new HIV infections among children must be continued, including by concentrating on prevention during the breastfeeding period and rolling out Option B+ strategies.

b) **HIV testing:** To encourage millions more people to know their HIV status, it is necessary to make it safer for people to get tested, not just easier for the healthcare system to test them. Reaching the 90-90-90 target will require renewed commitment to people- and community-centred testing.

c) **Access to affordable, rights-based treatment and related services:** Increase efforts to ensure ARV access through implementation of a minimal health care package, as well as making second and third line medication accessible to all. Services need to become increasingly client-friendly, stockouts must be prevented and health practitioners trained on the latest HIV guidelines. New models of service delivery – particularly community-based and nurse- and health worker-led – will be critical to lowering community viral loads. The response must ensure that intellectual property rights for ARV treatments, trade patents and trade agreements do not place profits over human lives. Access to palliative care for children and adults living with HIV must be expanded considerably.

d) **Increased funding for civil society, and sharing of AIDS experience:** A 3-fold increase in financial support for NGOs in the response is critical. At the same time, the independence of civil society organizations to set their own agendas must be assured. AIDS civil society has achieved an unprecedented degree of scientific knowledge and understanding of health politics. These skills remain central and must be expanded in the fight for cheap and accessible hepatitis C treatment, innovative TB treatment, healthcare for women and children, and HIV cure and vaccine research.

e) **Enabling legal environment and reforming laws that overly criminalize drug use, same-sex relations and sex work:** Address discrimination and inequalities faced by people living with HIV, and by LGBTQ community, sex workers, persons who use drugs and prisoners. Remove discriminatory laws and put in place policies that protect health and human rights, e.g. rehabilitative drug policies that minimise incarceration. Sensitize police, who can be a determinant of risk for key populations, to their capacity to play a positive role in HIV prevention.

f) **Economic, social, legal and political empowerment of women, including women living with HIV:** A range of multisectoral interventions must be implemented, including: investing in women-led networks; expanding treatment literacy for women; engaging women in designing, delivering and evaluating research; developing and rolling out female-controlled prevention methods; engaging men as role models in gender equality and positive masculinity; training service providers to provide non-judgmental support to women and girls and to provide strong referral pathways to other services (peer support,

legal services, economic empowerment); Equipping community and faith leaders to prevent and respond to HIV and gender based violence within their communities. Furthermore, ensure legal protection and recourse of women and girls against all forms of violence, including early and forced marriage, dating violence, marital rape, harmful traditional practices, coerced and forced sterilization for women living with HIV, and in conflict and post-conflict situations.

g) **Empowering and engaging young people:** Governments must prioritize the adoption and successful implementation of evidence-based, universally accessible, quality, non-judgmental comprehensive sexuality education, which is linked to comprehensive youth-friendly services, provided in a safe and participatory environment. Discriminatory laws that hinder access to HIV and SRH services must be removed. Young people living with HIV and orphaned by AIDS require focused psychosocial support in navigating stigma, disclosure, ART and relationships. Peer education is a particularly effective way of targeting difficult to reach groups, such as young people who do not attend school, with vital AIDS education. The meaningful participation of young people– including from key populations – must be ensured in political spaces, decision-making platforms and accountability mechanisms.

"The Joint Programme including the UNAIDS Secretariat can help by establishing bridges between government and young key population organizations at the country level and by publishing an agreed definition of youth-friendly services…"

Consultation participant

h) **Stigma and self-stigma reduction:** Sensitizing health care workers and the media can play a central role in reducing stigma across society. HIV treatment programmes must be integrated with rights-based mental health services that address issues of self-stigma. More investment must be made in partnerships with faith leaders, and their capacity building in reducing stigma and discrimination.

i) **Integration of health services, including HIV, TB, neglected tropical diseases and NCDs:** Integration must occur at all levels from government to primary care clinics. HIV diagnosis, including paediatric, needs to be integrated into a larger healthcare model that supports general health-maintaining behaviours, nutrition, child survival and sexual and reproductive health. Integration of HIV and NCDs services are particularly necessary to serve older people living with HIV. Integrated care issues should also be considered for specific groups, such as the positive impact of access for transgender people to hormones, on self-worth and HIV prevention and treatment outcomes.

j) **Clearer understanding of the epidemic through strategic information:** Participants called for more data collection on modes of transmission, most affected populations and their size, geographical variations in HIV burden, structural determinants of vulnerability and investment needs. Data and research findings must be at the minimum age- and sex-disaggregated.

k) **Multisectoral, structural determinants of vulnerability:** The leadership and engagement of ministries of health must be complemented by that of other sectors, including justice and education. Greater balance is necessary between the biomedical aspects of the response, and the psychosocial, socio-political and economic needs of people living with and at risk of HIV. Social protection and nutritional support, including for older people caring for people living with HIV and OVCs, is critical.

l) **Financing:** Urgent and rapid scale-up will rely on significant investments from domestic and international sources. As funding sources, levels, and donor priorities continue to evolve, the UNAIDS strategy must reinforce the need for sustainable and diversified investments from UN agencies, UN Member States, Private Sector, and other key stakeholders. The international community has an obligation to ensure that essential programmes for key populations in MICs are adequately funded.

4. WHAT WILL NEED TO CHANGE IN SUPPORT OF THOSE PRIORITIES? WHAT ARE THE "GAME-CHANGERS"?

Leadership

Bold political leadership can overcome many of the gaps in the AIDS response. Leadership is paramount to ensuring resources are allocated to where they are required most, and to rooting out corruption and misuse of HIV funds. Bold leadership can guide legal reform that will unlock rapid, and cost-effective progress in the response.

New prevention technologies, including cure or vaccine

The lack of progress in developing a cure or vaccine may be as much a result of scientific challenges as it is a lack of will on the part of the pharmaceutical industry. Advocacy and public pressure must be stepped up. PrEP can also be a game-changer, not just in its efficacy to prevent new infections, but in involving at-risk populations in sexual health monitoring and care and bringing NGO-led prevention and health system-led care together. Current barriers to scaling up PrEP include funding, lack of registration of Truvada for prevention, lack of health provider knowledge and willingness to prescribe PrEP and lack of demand from high-risk communities. All of these (and other) barriers need to be addressed and removed.

Use of mobile, online and social media tools

Online and social media tools should be utilized for a number of purposes: Informing and mobilizing communities to demand service access, policy change and political accountability; Comprehensive social media activations to alert the public of new policies and medical advancements; Safe anonymous space to share sexual health information with young people; Recruitment of high profile personalities in sports, film, music, fashion etc to leverage their online presence for HIV awareness raising. A comprehensive directory of advocacy and civil society groups at the country level should also be compiled in a central location, that can act as a platform for collaboration and knowledge-sharing.

The potential for mHealth technology to improve adherence and reduce loss-to-follow- up is being increasingly recognized and should be promoted as a key area of innovation.

5. WHAT ARE THE MOST CRITICAL WAYS IN WHICH THE UNAIDS JOINT PROGRAMME CAN SUPPORT EFFORTS TO END AIDS AS A PUBLIC HEALTH THREAT BY 2030?

Support countries in articulating strategic plans: Most countries still lack serious, costed national strategies that rely on sound epidemiological analysis to deploy proven interventions, prioritizing based on realistic financial plans. UNAIDS needs to continue its leadership in supporting countries to design clear and strategic investment framework.

Create political pressure: Few countries have garnered the political capacity to deploy smart plans even if they're developed, so good plans must be backed by serious political pressure. This means taking big risks, leveraging all levels from civil society to big donors to giant corporations to persuade and support political leaders to engage fully.

"We need a more robust response from UNAIDS to those countries who continue to work against an enabling environment and/or continue to neglect scientific evidence in their HIV policy positions."

Strengthen UNAIDS capacity on human rights: Capacity at the country level must be strengthening to lead on implementation of human rights programming.

Focus resources: UNAIDS' resources should be focused on areas, at the sub-national level, that account for the greatest HIV burden.

Lead integration movement: Demonstrate technical and political leadership in how to bring gender, human rights, poverty alleviation, education, reproductive health stakeholders together and work for joint progress.

Protect and promote civil society: Implementing the Fast-Track strategy will rely on a more robust response from UNAIDS in protecting the role of civil society to advocate for an enabling social, legal and political environment, engage in governance at all levels and engage in service delivery and evaluation.

Monitor and hold accountable: Effective accountability mechanisms will ensure transparency in how States are using their resources in the AIDS response, ensure marginalized populations are adequately reached, and guarantee greater effectiveness. UNAIDS plays a central role in carrying out and encouraging robust performance monitoring and a focus on results – and must strengthen this role. UNAIDS strategy should be built around meaningful, measurable and harmonized targets and indicators

Virtual Consultation Participating Organizations

Official submissions

1. Government of Belgium
2. Government of Canada
3. Government of Italy
4. Australian Federation of AIDS Organisations (AFAO)
5. Center for Reproductive Rights
6. Coalition for Children Affected by AIDS
7. Elizabeth Glaser Pediatric AIDS Foundation
8. Handicap International, Senegal/Cape Verde/Guinea Bissau
9. HelpAge International
10. International Children's Palliative Care Network
11. International Community of Women living with HIV/AIDS (ICW)
12. International Disability and Development Consortium (IDDC)
13. International Planned Parenthood Federation
14. Médicos del Mundo Spain
15. The PACT
16. Regional Interagency Task Team on Children and AIDS (RIATT-ESA).
17. SERES (con) viver com o VIH, Portugal
18. Worldwide Hospice Palliative Care Alliance

Organizational representation
Members of the below organizations participated in the virtual consultation (not all participants shared their affiliation).

1. ACT!2015 National Youth Alliance in South Africa
2. AIDS Society of Asia and the Pacific
3. Asia Pacific Network of Young Key Populations
4. **Association Marocaine de Solidarité et de Développement (AMSED)**
5. Association of Nurses in AIDS Care (ANAC)
6. CAReTT, Trinidad & Tobago
7. Catholic Relief Services
8. Center for Research in Infectious Diseases, Mexico City
9. Citizens Health Watch, Zimbabwe
10. European AIDS Treatment Group
11. Global Network of People Living with HIV North America (GNP+NA)
12. Handicap International Federation, France
13. HelpAge International, UK
14. <u>HIV Disclosure Project</u>, Canada
15. INA (Māori, Indigenous & South Pacific) HIV & AIDS Foundation
16. International HIV/AIDS Alliance
17. International Indigenous Working Group on HIV & AIDS, Canada
18. International Women's Health Coalition
19. Law Enforcement and HIV Network (LEAHN)
20. Positively UK
21. Pozityvus gyvenimas (Positive Life), Lithuania
22. Stepping Stones International, Botswana
23. The AIDS and ART Foundation (TAAF), Zimbabwe
24. United States Centers for Disease Control and Prevention (CDC)
25. University of Washington, USA
26. Women's Organisation Network for Human Rights Advocacy (WONETHA), Uganda
27. Youth Voices Count, Sri Lanka

Discussion note
Consultation on UNAIDS Strategy 2016-2021:

GLOBAL MULTISTAKEHOLDER CONSULTATION

Geneva, 22-23 April 2015

OVERVIEW

To inform development of the updated UNAIDS Strategy for 2016-2021, UNAIDS convened a global consultation in Geneva on 22-23 April, 2015. The consultation generated a robust, interactive discussion that identified key achievements and gaps in the AIDS response, as well as environmental changes that will affect the global community's ability to end the AIDS epidemic as a public health threat by 2030. As the anticipated endorsement of the updated UNAIDS strategy in 2015 will coincide with that of the Sustainable Development Goals (SDG) for the post-2015 era, and recognizing the deep interconnectedness of the AIDS response with issues across the SDG agenda, the consultation also focused on lessons learned in the AIDS response and opportunities to strengthen cross-sectoral collaboration. The consultation produced specific recommendations for the updated UNAIDS Strategy 2016-2021.

More than 100 people participated in the two-day consultation. Participants included representatives of governments of low- and middle-income countries, key international donors, international non-governmental organizations, faith-based organizations and a broad array of other community and civil society organizations, including NGO representatives on the UNAIDS Programme Coordinating Board.

The April consultation was framed by a series of strategic questions, which provoked a lively discussion among participants, informed by a background paper.

The global consultation in April complements regional consultations held in every region, including the seven UNAIDS regions as well as North America and Western Europe. The April consultation also supplements inputs from a virtual consultation which ran from 23 March through 2 April and which generated more than 280 inputs from 50 countries.

There was widespread agreement at the April consultation that the updated UNAIDS Strategy should build on the current UNAIDS Strategy 2011-2015 and on achievements to date in the AIDS response. The consultation strongly reaffirmed the UNAIDS vision of *zero new HIV infections, zero discrimination and zero AIDS-related deaths*. Participants also agreed in the continuing need to pursue the current Strategy's three strategic directions: (1) revolutionize HIV prevention; (2) catalyse the next phase of treatment, care and support; and (3) advance human rights and gender equality for the HIV response.

This report summarizes key outcomes of the April consultation, with particular attention to recommendations for the updated UNAIDS Strategy 2016-2021. This report does not aim to capture every intervention by participants but rather to summarize key themes that emerged from the consultation.

THE STATE OF THE AIDS RESPONSE: ACHIEVEMENTS TO DATE AMIDST A CHANGING ENVIRONMENT

Consultation participants reviewed the unprecedented gains in the AIDS response since the 2001 Special Session of the United Nations General Assembly on HIV/AIDS. In the face of considerable scepticism, the AIDS response has achieved substantial, sustained reductions in the number of new HIV infections. Today, fewer than 200 000 children are newly infected with HIV, as the world advances towards the goal of eliminating new infections among children and keeping their mothers alive. The world is presently on track to reach its 2015 target of providing antiretroviral therapy to 15 million people.

Although the human rights agenda in the AIDS response is still unfinished, the response has demonstrated the feasibility of overcoming discriminatory barriers. For example, there has been a consistent decline in the number of countries with HIV-related restrictions on entry, stay or residence, with the vast majority (140) of countries now welcoming travellers living with HIV.

Political leadership on AIDS, which participants highlighted as a critical ingredient of achievements to date, remains strong. In 2015, the United Nations Economic and Social Council passed its most advanced resolution yet on the AIDS response. UNAIDS attracted strong support at the United Nations General Assembly in September 2014 for ambitious new targets to end the AIDS epidemic. Strong leadership on AIDS is apparent in diverse regions. In the Middle East and North Africa, where responses have traditionally lagged behind those in other regions, the Arab League has stepped forward to articulate a comprehensive AIDS strategy and to endorse non-discrimination in the response. South Africa is now fast-tracking its national response in 72 districts, leveraging granular strategic data to accelerate progress towards the 90-90-90 targets. Cities are also taking action, with Abidjan designing a comprehensive package of focused actions to lay the groundwork to end its local epidemic.

The AIDS response has changed the way leaders perceive funding for health, understanding such funding as an investment rather than an expense. The African Union launched a roadmap for global solidarity and shared responsibility, recognizing that increasing domestic resources reduces dependency on international assistance and accelerates progress in the response.

Recent achievements have set the stage for the push to end the epidemic once and for all by 2030. Modelling indicates that the next five years offer a fragile window of opportunity to lay the foundation for ending the epidemic. By contrast, 'business as usual' would result in a reversal of gains made and an increase in the annual number of new HIV infections and AIDS-related deaths. Unless further progress is made in increasing access to essential services for HIV prevention, treatment, care and support, 60 million people will have died of AIDS-related causes by 2030. Given the limited time in which to act, it is essential to fast-track the AIDS response in order to seize historic opportunities and avoid a worsening of the epidemic.

In its efforts to catalyse a fast-tracking of the response, UNAIDS and its many partners and stakeholders in the response will need to take account of a rapidly evolving environment. In 2020, middle-income countries will be home to 70% of people living with HIV, underscoring that the effort to end AIDS will in large measure be won or lost in middle-income countries. With the number of displaced persons rising by more than 24% since 2006, conflict and emergencies have the potential to weaken national AIDS responses and increase risk and vulnerability. Economic and social inequality, which is closely linked to HIV prevalence, is increasing, both exacerbated by and resulting in unequal access to power, education, food

and health care. Just as the world is rapidly urbanizing, with 56% of the world's people projected to live in urban settings by 2020, the epidemic itself is becoming increasingly urban.

While participants examined challenges posed by a rapidly evolving environment, they also recognized new opportunities. The focus on integration and multi-sectorality in the post-2015 development agenda may expand the latitude for action to address underlying social and economic determinants of HIV risk and vulnerability. Changing environments may also expedite critical changes in attitudes and perceptions; for example, the upcoming Special Session of the United Nations General Assembly on drug policy represents a historic opportunity to better align the global approach to drugs to public health and human rights principles.

PERSISTENT GAPS IN THE AIDS RESPONSE: ENSURING THAT NO ONE IS LEFT BEHIND

To reach fast-track targets for 2020 and end the epidemic by 2030, the AIDS response will need to intensify and achieve even better results in the next five years. While the number of new HIV infections in 2013 was 33% lower than in 2005, gains in HIV prevention have been insufficient. Important technological innovations have emerged in the prevention field, but the world has yet to see the prevention revolution envisaged by the UNAIDS Strategy.

Although the world is poised to reach its HIV treatment target for 2015, more than 20 million people living with HIV remain without life-saving treatment services. Furthermore, of the millions of people on HIV treatment, only a fraction are virally suppressed.

To achieve the 90-90-90 targets for 2020, a particular focus on knowledge of HIV status is essential. Although 85% of people who know their HIV status are receiving antiretroviral therapy, an estimated 19 million people living with HIV remain undiagnosed and beyond the reach of treatment programmes. Among people living with HIV, men are notably less likely than women to know their HIV status. New strategies and technologies, such as HIV self-testing, oral-based rapid tests and diverse community-based approaches, will need to be mobilized to reach the global target of 90% knowledge of HIV status among people living with HIV.

Many populations are being left behind by the response. Due to gaps in HIV diagnosis and treatment access, children living with HIV are notably more likely to die than adults living with HIV. Adolescents and young adults remain at the centre of the AIDS challenge, accounting for a disproportionate share of new HIV infections and AIDS-related deaths; even though AIDS-related deaths overall fell by 35% from 2005 to 2013, AIDS-related deaths among adolescents rose by 50% during this same period. In sub-Saharan Africa, girls and young women account for three out of four new HIV infections among young people. It is estimated that, along with their sex partners, five groups – men who have sex with men, people who inject drugs, prisoners, sex workers and transgender people – account for up to half of new HIV infections but experience substantial barriers to service access. Other populations whose needs have yet to be effectively addressed include migrants, people with disabilities, racial minorities, people affected by conflict or disaster and people over age 50.

Although communities themselves are invaluable for identifying and overcoming the policy and programmatic barriers they confront, community resources remain insufficiently leveraged in the response. In the case of HIV treatment, community- and peer-based approaches are associated with improved rates of treatment adherence and retention, but these have yet to be brought to scale and effectively resourced. Networks of people living

with HIV and civil society organizations bring passion, critical knowledge and an intimate understanding of programmatic and policy gaps to the response. UNAIDS modelling for the fast-track approach indicates the need for a substantial increase in the proportion of HIV services provided through community channels, which in turn will require increased investments in community systems. However, financing for local networks of people living with HIV and other community-driven responses continue to be acutely under-financed.

As underserved populations vary from setting to setting, planners and programme implementers need a granular understanding of their epidemic. In many places, however, strategic information systems have not been devised or effectively leveraged to permit a strategic targeting of limited financial and technical resources to settings and populations where need is greatest.

Stigma, discrimination and human rights violations continue to undermine responses across the world, prompting participants in the consultation to urge that the human rights response be fast-tracked. It was noted that discrimination in health care settings emerged as the primary barrier to service access cited by people living with HIV in consultations for the updated UNAIDS Strategy. Criminalization of sex work, drug possession and same-sex relations – as well as criminalization of HIV exposure, transmission or non-disclosure – further drive many people away from essential HIV services.

Gender inequality increases the HIV risk and vulnerability of women and girls and diminishes their access to essential information, services and support. Women and girls need the ability to control their bodies, economic conditions and reproductive decisions, and to be free from violence. The lack of prevention methods that women may control or initiate on their own is a critical gap in the response, as innovation has yet to move at the same pace for women as for men.

Even as the AIDS response has mobilized unprecedented resources for health, a substantial gap exists between amounts currently available for HIV programmes and those that will be needed to fast-track the response. In particular, a potential AIDS financing crisis looms for middle-income countries, which in future years will be home to the large majority of poor people and people living with HIV. The ineligibility of middle-income countries for international aid threatens gains made to date and poses particular risks for programmes focused on marginalized populations which are often supported by international resources.

THE AIDS RESPONSE AND SUSTAINABLE DEVELOPMENT: OPPORTUNITIES IN THE POST-2015 ERA FOR JOINT, CROSS-SECTOR ACTION

Participants identified some of the hallmarks of the emerging approach to sustainable development for the post-2015 era as universality, integrated and multi-sectoral action, and diverse and innovative partnerships. This emerging approach, emphasizing the inter-connectedness of health and development, offers the AIDS response opportunities to promote synergies across development goals and sectors.

In many respects, the AIDS response anticipated the emerging approach to sustainable development, affording lessons that apply across the health and development spectrum. The AIDS response has been distinguished by its people-centred and community-driven approaches; commitment to evidence-based action; agreement on concrete, time-bound targets and timely, rigorous, routine monitoring of progress; a commitment to human rights and gender equality; a focus on evidence-based strategies and approaches; engagement, inclusion and empowerment of affected communities and civil society; and the cultivation of strategic partnerships.

The Sustainable Development Goals present multiple opportunities to integrate AIDS across the development agenda, not merely within the health goal. For example, HIV-sensitive policies and programmes have an important role to play in a broad array of development objectives, including education, poverty reduction and sexual and reproductive health and rights.

In particular, the Sustainable Development Goals will enable multisectoral solutions to shared determinants, such as joined-up coalitions and movements for social protection, nutrition, local manufacture of essential medicines, gender equality and reduction of gender-based violence, and evidence- and rights-based approaches to drug and alcohol dependence. The agenda further demands action to negotiate and deliver global public goods, such as disease surveillance and strategic information systems, research and development, affordable medicines (including common approaches to overcoming intellectual property and trade barriers to manufacture and uptake of priority medicines and diagnostics), civil society activism and promotion of a global norm of health as a political and economic priority.

Participants recommended that the AIDS response avoid trying to demonstrate relevance across all 17 Sustainable Development Goals but instead focus on key goals that will affect the future success of the response the most. Within the context of a more integrated, universal development agenda focused on sustainability, the AIDS response should endeavour to protect its unique aspects within an expanded health and development agenda, including the participation and empowerment of affected communities, rights-based multisectoral responses, removing punitive laws, and leveraging clear and time-bound targets to drive progress.

FAST-TRACKING THE AIDS RESPONSE: SUMMARY OF CALLS FOR THE UPDATED UNAIDS STRATEGY 2016-2021

Much of the discussion at the global consultation focused on what UNAIDS can do to close gaps in the global response, fully leverage opportunities under the Sustainable Development Goals, and fast-track responses to lay the groundwork to end the AIDS epidemic. Participants offered concrete suggestions on specific components of the AIDS response and on key principles and cross-cutting issues, summarized below. It was noted that feedback provided by participants in the global consultation largely mirrored and affirmed input provided in earlier regional consultations.

Strengthen UNAIDS leadership and political advocacy

It was agreed that UNAIDS should continue and further strengthen its recognized role in building and sustaining strong leadership on AIDS. In this respect, UNAIDS should promote the AIDS response as a universal agenda, emphasizing the global nature of the AIDS challenge and the shared responsibility to end the epidemic. Participants noted, for example, that severe and often expanding epidemics exist in many high-income countries. In building leadership in the response, UNAIDS should also cultivate new AIDS champions, including by finding ways to involve and engage ministries beyond the health sector. As city action will be vital to fast-tracking the response, particular efforts will be needed to mobilize mayors and other city leaders in the push to end the epidemic. Across its efforts to build strong leadership on AIDS, UNAIDS should foster country ownership, coordination, good governance and accountability.

Participants further encouraged UNAIDS to be bold in its political advocacy, with particular attention to building consensus on difficult issues and saying things that others can't or won't. Particular asks were made for UNAIDS advocacy and support in protecting the role of civil society at the country level, which some participants recognized as increasingly at risk.

Prioritize HIV prevention

Participants recommended that UNAIDS prioritize assistance to countries in assembling optimally effective packages of combination prevention. Multi-faceted prevention programmes must be accessible for all, especially vulnerable groups, and include condoms and lubricants, needles and syringes, opioid substitution therapy, HIV testing, pre-exposure antiretroviral prophylaxis and voluntary medical male circumcision. Comprehensive sexuality education and sexual and reproductive health and rights are fundamental pillars of effective HIV prevention. Primary prevention efforts, including behaviour change and condom promotion, need to linked to, and synergistic with, scaled-up HIV treatment services.

Catalyse progress towards 90-90-90

Work to catalyse progress towards the 90-90-90 target should occupy a central place in the UNAIDS strategy. Consistent with the paradigm shift reflected by the 90-90-90 target, UNAIDS efforts on HIV treatment should span the full treatment cascade, with the ultimate goal of maximizing the proportion of people living with HIV who achieve viral suppression. Particular attention is needed on accelerating progress towards the global goal of 90% knowledge of HIV status among people living with HIV.

Focus on women and girls

Participants urged UNAIDS to intensify its focus on women and girls, with particular attention to understanding and responding to social determinants of risk and vulnerability. UNAIDS was urged to prioritize women's social, economic, legal and political empowerment. Participants encouraged UNAIDS to include gender-responsive strategies and indicators across all three strategic directions and cross-cutting issues. The updated UNAIDS Strategy should promote gender norms that support women's rights and autonomy, and boys', men's, girls' and women's access to sexual and reproductive health services. Continued investments are needed in accelerated efforts to develop prevention methods that women and girls can control and initiate on their own. In the quest to reduce the risk and vulnerability of women and girls, efforts to reduce risky behaviour among men and boys will be essential. In its updated strategy, UNAIDS should specifically focus on ensuring robust financing for programmes to address the HIV-related needs of women and girls.

Accelerate results for children

Efforts to address the HIV-related needs of children will need to be intensified under the updated UNAIDS Strategy. UNAIDS was strongly advised to lead global efforts to close the paediatric HIV treatment gap. Participants highlighted the unique needs of children of key populations as well as HIV-negative children of parents living with HIV that too often go unaddressed. For young children, steps should be taken to ensure inclusion of parents and caregivers in HIV services, as children's access depends on access for their caregivers.

Empower young people

Particular attention should focus on promoting youth leadership through such strategies as capacity building, mentoring and broader engagement of young people. Further investments are needed in innovative strategies to increase AIDS awareness among young people and

to encourage risk reduction and voluntary HIV testing. UNAIDS should encourage countries to ensure that adolescents receive needed commodities, education, economic empowerment, prevention of violence and discrimination, and support through community systems strengthening.

Solidify role as protector of human rights

Participants encouraged UNAIDS to further strengthen its leadership on human rights issues. UNAIDS was advised to pursue a clear, consistent advocacy agenda for a human rights-based response and to ensure that leadership on human rights issues extended from the headquarters to all regional and country offices. By establishing itself as a clear protector of human rights, participants said, UNAIDS could be optimally effective in fostering an enabling legal environment for the AIDS response. Particular attention should be paid to eradicating stigma and discrimination in health care settings and to ensuring access to justice for people living with or affected by HIV. Participants urged UNAIDS to take bold, visible stances in opposition to criminalization schemes.

Strengthen strategic information in partnership with communities

The collection, analysis and effective use of strategic information is essential, and promoting this outcome is a core function of UNAIDS. Continued work should aim to galvanize the collection and use of more granular data to inform resource allocation and programmatic targeting by location and population. A call emerged to prioritize the collection of disaggregated data that reveals disparities along the lines of age, sex, race, legal status, key population, etc. Engaging communities themselves through participatory research and data collection is a valuable strategy to increase strategic information with respect to marginalized populations whose behaviours are criminalized.

Maximize the potential of innovation

UNAIDS should encourage and fully leverage innovation as a touchstone of the fast-track response. Specific actions are needed to maximize under-utilized strategies and tools, including self-testing, pre-exposure antiretroviral prophylaxis, service decentralization and community leadership.

Strengthen leadership on commodity price reductions, research and development

Participants encouraged UNAIDS to prioritize action to increase the accessibility of antiretroviral medicines and diagnostics, including through intensified efforts to overcome intellectual property issues, utilize TRIPS flexibilities and achieve further price reductions. Additional attention is warranted to catalyse the development of affordable, less toxic second- and third-line antiretroviral regimens, as well as effective and affordable treatments for co-morbidities such as hepatitis B and C. At the same time that it prioritizes work to expedite uptake of existing tools, UNAIDS should undertake focused efforts to galvanize progress towards development of a preventive vaccine and a cure for HIV infection.

Guide evidence-informed integration and cross-sector action

In keeping with the thrust of the post-2015 agenda for sustainable development, UNAIDS should prioritize integration of HIV services into the broader health system, as well as guiding more effective cross-sectoral action on the social determinants of vulnerability. UNAIDS was encouraged to focus on documenting and disseminating the benefits of mutli-sectorality, in order to identify best practices, build support and financing for cross-sectoral action and to increase awareness of the pertinence of the AIDS response across the broad

health and development agenda. Specific efforts are recommended to identify opportunities to jointly promote social protection, economic empowerment, education, gender equality, urban planning, and social and legal equality and non-discrimination for marginalized communities.

Mobilize sustainable diversified investments to fast-track the response

UNAIDS was requested to continue and strengthen its work to mobilize essential investments in the AIDS response, with a particular emphasis on front-loading of investments to reach fast-track targets. Resource mobilization should continue to be guided by principles of global solidarity and shared responsibility. Countries that have not developed HIV investment cases should be assisted in doing so, and UNAIDS should work to disseminate and leverage lessons learnt from Zimbabwe's AIDS trust fund and other domestic and innovative funding mechanisms. Specific strategies will be needed to ensure adequate funding for programmes focused on key populations in middle-income countries, including through the replenishment of the Robert Carr civil society Networks Fund. Furthermore, recognizing that low-income and lower-middle-income countries will continue to need substantial external assistance, participants asked UNAIDS to prioritize advocacy for the continued engagement and leadership of international donors.

Put "people-centred" into practice

Consistent with a people-centred approach, the updated UNAIDS Strategy should prioritize inclusion. Participants advised UNAIDS to lead a transition in the response from a commodity-driven to a community-driven approach. People living with and affected by HIV should be engaged in all aspects of the response, and particular efforts are needed to engage populations who are being left behind as key partners in strategy development, advocacy and service delivery.

Build resilience among fragile communities

The updated UNAIDS Strategy should aim to be crisis-sensitive and optimally resilient. Rapid response mechanisms should be in place to respond to unfolding emergencies, with the aim of preserving services and mitigating risk and vulnerability. In addition to fragile states, the updated UNAIDS Strategy should also recognize that fragile communities also require intensified support, even in the most affluent countries.

Invest in strategic partnerships including with civil society and the private sector

UNAIDS should aim to cultivate and support 'smart partnerships'. UNAIDS neither cannot nor should not aim to engage with every conceivable partner but instead should focus on partnerships that are strategic and efficient.
Participants advised UNAIDS to expand its partnerships with civil society. UNAIDS should encouraged robust investments in civil society and community systems and should work to empower and create space for civil society in governance, activism, service delivery, demand creation and other aspects of the response. Assistance to countries should be provided to re-engineer health systems to recognize and facilitate the role and contribution of civil society. Participants urged UNAIDS to renew and revive its partnerships with faith-based organizations.

Looking beyond the notion of simple corporate social responsibility, UNAIDS should work to convince private companies that investing in the AIDS response is good business. In this regard, further progress is needed in implementing workplace AIDS programmes, which

have the particular potential to engage men in HIV prevention, testing and treatment services.

Participants noted that numerous actors, including the Global Fund to fight AIDS, Tuberculosis and Malaria, are also in the process of renewing or revising their respective strategic plans. Through communication and collaboration, UNAIDS should work to ensure that its updated Strategy is optimally aligned with the strategic plans of partners.

CLOSE – NEXT STEPS

Following the discussion of a draft outline of the updated Strategy at the Programme Coordinating Board meeting in June, UNAIDS will generate a full draft of the updated Strategy in July. A virtual consultation will elicit feedback on this draft in order to permit finalization of the updated Strategy prior to the Programme Coordinating Board meeting in October.

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