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THE PRESIDENT OF THE GENERAL ASSEMBLY

LE PRESIDENT DE L'ASSEMBLEE GENERALE

08 June 2011

High-Level Meeting on AIDS

Background

Three decades into the AIDS pandemic, ten years after the adoption of the Declaration of Commitment on HIV/AIDS and five years after the adoption of the Political Declaration on HIV/AIDS, Member States will come together to review progress and chart the future course of the global AIDS response at the 2011 UN General Assembly High Level Meeting on AIDS from 8 –10 June 2011 in New York.

General Assembly Resolution A/RES/65/180PDF requests the President of the General Assembly to organize, as part of the preparatory process, no later than in April 2011, an informal interactive civil society hearing. This will take place on 8 April 2011, further information on civil society participation can be found through the link provided in the resources section of this page. .

H.E. Gary Quinlan, Permanent Representative of Australia and H.E. Charles Ntwaagae, Permanent Representative of Botswana have been appointed by the President of the General Assembly to act as co-facilitators and will hold timely, open, transparent and inclusive consultations with all Member States, with a view to adopting a concise and action-oriented declaration as an outcome of the High-level review.

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Implementation of the Declaration of Commitment on HIV/AIDS and the Political Declaration on HIV/AIDS

Uniting for universal access: towards zero new HIV infections, zero discrimination and zero AIDS-related deaths

Report of the Secretary-General

Summary

The year 2011 marks 30 years of AIDS. In that time, AIDS has claimed more than 25 million lives and more than 60 million people have become infected with HIV. Still, each day, more than 7,000 people are newly infected with the virus, including 1,000 children. No country has escaped the devastation of this truly global epidemic.

Nevertheless, HIV programmes are now bearing fruit, with global HIV incidence declining, treatment access expanding and an unparalleled global movement mobilized to demand respect for the dignity and human rights of everyone vulnerable to, and affected by, HIV. The epidemic and the response it has generated have changed our world, elevating global health inequity on the worldwide political agenda and placing people at the centre of health, development and human rights efforts.

These accomplishments, while promising, are insufficient and in jeopardy. Stigma, discrimination and gender inequality continue to undermine efforts to achieve universal access to HIV prevention, treatment, care and support. An unsustainable trajectory of costs and the effects of a global economic downturn combine to threaten progress.

For three decades, evidence of what works has been debated in the General Assembly, parliaments, communities, places of worship and scientific forums. The international community enters the fourth decade with a vast body of knowledge and an array of new tools to revolutionize prevention efforts and dramatically scale up access to treatment, care and support.

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The HIV response faces a moment of truth: 2011 marks a unique opportunity to take stock of progress and to critically and honestly assess the barriers that keep us shackled to a reality in which the epidemic continues to outpace the response.

Bold decisions must be taken to dramatically reshape the AIDS response to reach zero new HIV infections, zero discrimination and zero AIDS-related deaths. This requires rejuvenated political commitment for more focused, efficient and sustainable responses. It requires recognition that non-discrimination, pragmatism and compassion will yield benefits not only for the HIV response but also across health, development and human rights priorities.

Bridging the gaps

- For every person starting treatment, two are newly infected. Ending new HIV infections will require harnessing innovation, putting people living with HIV at the centre of the response, protecting human rights and eliminating gender inequality.
- Global AIDS resources have flatlined. Shared responsibility is required to protect access for more than six million people receiving HIV treatment and to bring treatment to the millions who are still in need.
- The trajectory of costs is wholly unsustainable. Resources must be focused on evidence-informed actions that will generate efficiency and sustainable results while promoting country- and people-owned responses.
- HIV responses must take advantage of the global momentum gathering for global health, with special emphasis on gender, and align and integrate with efforts to achieve the Millennium Development Goals.
- Critical sources of leadership and accountability remain untapped. Emerging political powers, affected countries and people living with and vulnerable to HIV — including men who have sex with men, people who buy and sell sex and people who use drugs — must exercise greater leadership in the governance of HIV responses.

Mobilizing for impact: five recommendations

The present report contains the following five recommendations for all stakeholders:

(a) Champion a prevention revolution that harnesses the energy of young people and the potential of new modes of communication that are transforming the world, rescinds punitive laws that block effective responses and ensures that people are empowered to protect themselves, their partners and their families from HIV;

(b) Forge a revitalized framework for global solidarity to achieve universal access to HIV prevention, treatment, care and support by 2015;

(c) Break the upward trajectory of costs and deliver more effective, efficient and sustainable programmes;

(d) Ensure that our responses to HIV promote the health, human rights, security and dignity of women and girls;

(e) Commit to forging robust mutual accountability mechanisms.

I. Introduction

1. When Member States convened at the United Nations in 2001 for the twenty-sixth special session of the General Assembly on HIV/AIDS, the world was losing the struggle against HIV. In 2001, the number of people living with HIV was increasing, therapies revolutionizing the HIV response in high-income countries were virtually unavailable in the most severely affected countries and total resources spent on HIV activities in low- and middle-income countries amounted to only about 10 per cent of spending in 2009. The epidemic was reversing decades of development progress in sub-Saharan Africa, threatening stability and security, and exacerbating global inequity in health.

2. The 2001 special session resulted in a visionary Declaration that included time-bound targets in the response. The special session gave rise to a major global health financing institution, namely the Global Fund to Fight AIDS, Tuberculosis and Malaria. Pledging additional steps to strengthen the response, Member States embraced a complementary set of commitments in the 2006 Political Declaration on HIV/AIDS, including the pledge to achieve universal access to HIV prevention, treatment, care and support.

3. Ten years after the landmark 2001 special session, the response to HIV has become perhaps the most compelling example of the power of international solidarity, evidence-informed action and political commitment. These achievements, although heartening, are exceedingly fragile.

4. The HIV response faces a moment of truth. HIV programmes are now bearing fruit, with the global HIV incidence declining, access to treatment expanding and a global movement mobilized to demand dignity and human rights for everyone affected by HIV. The HIV response has changed our world, elevating global inequity in health onto the political agenda, contributing to progress across the broad array of Millennium Development Goals and placing people at the centre of health and development efforts. These accomplishments, however, are in jeopardy. Aid fatigue and an enduring global economic downturn combine to threaten future support for essential initiatives.

5. The year 2011 is a historic marker in the global response; it allows the international community to review the progress of the last decade and marks 30 years into the epidemic. The international community must take this opportunity to reflect on lessons learned, reinvigorate and retool the response for the long term and maximize benefits for people most affected.

6. This report assesses progress and gaps in the response, based on data submitted by 182 countries and on national and regional reviews on universal access to HIV prevention, treatment, care and support.[1] Key findings include the following:

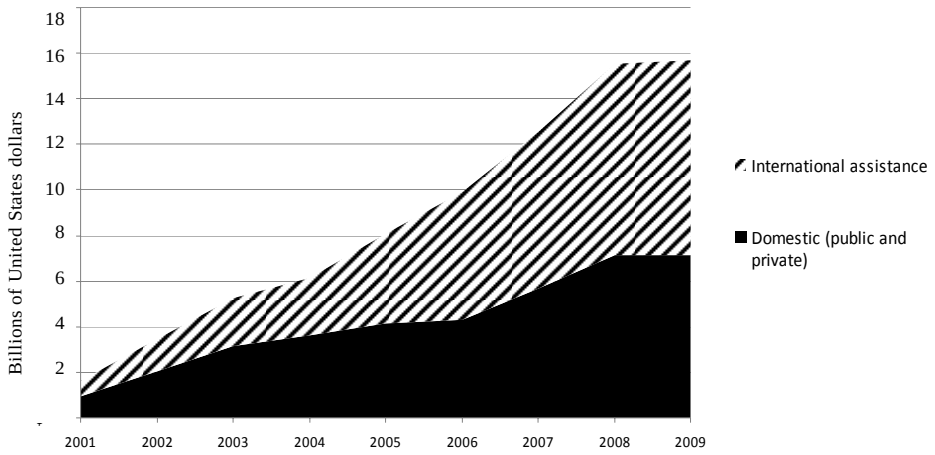
- **HIV prevention**. The number of people newly infected with HIV declined by 19 per cent in the decade before December 2009, with at least 33 countries experiencing a decline in HIV incidence of at least 25 per cent and 10 high-prevalence countries achieving the global goal of reducing HIV prevalence

[1] Due to an inevitable lag in reporting from countries, this report relies mainly on data received as at December 2009.

among young people by at least 25 per cent. Nevertheless, the epidemic continues to outpace the response, underscoring the need to revolutionize efforts to prevent new infections.

- **Antiretroviral therapy**. As at December 2010, more than six million people were estimated to be receiving antiretroviral therapy in low- and middle-income countries. Yet the majority of people in need still lack access.
- **Towards an HIV-free generation**. Global coverage for antiretroviral prophylaxis to prevent the vertical transmission of HIV has exceeded 50 per cent. However, more than 10 years after interventions were validated to prevent vertical transmission in resource-limited settings, the world remains far from achieving the goal of protecting newborns from becoming infected.
- **Human rights**. About three in 10 countries worldwide still lack laws prohibiting HIV-related discrimination. More than half of countries reported having laws or policies that indirectly or inadvertently reduce service access for vulnerable populations. Many of the countries with anti-discrimination laws do not rigorously enforce them.
- **Financing the response**. Funding for HIV programmes has dramatically increased, helping drive an overall surge in global health financing (see figure I). Nonetheless, in 2009, international HIV assistance declined for the first time, mirroring reductions in other forms of development aid.

Figure I
Total annual resources available for AIDS, 2001-2009



Source: Joint United Nations Programme on HIV/AIDS, 2011.

II. Thirty years of AIDS: reviewing the past, looking towards the future

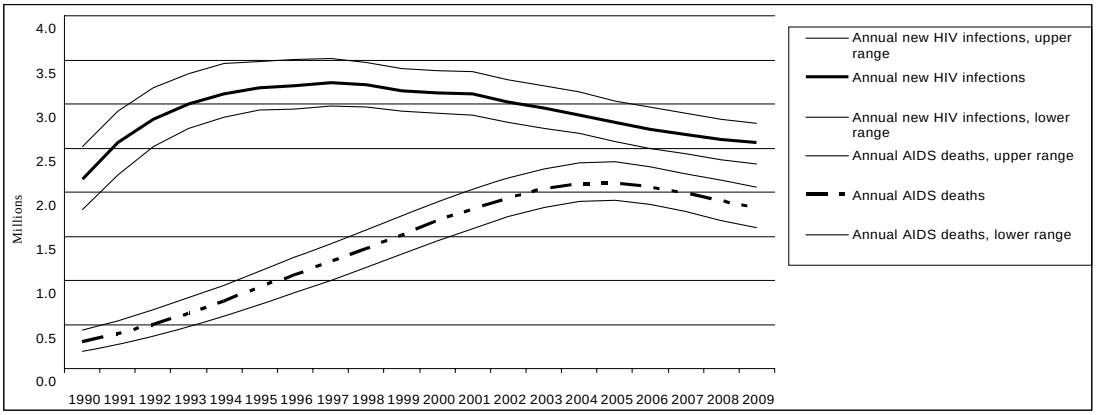
7. In 2009, an estimated 33.3 million people were living with HIV, a 27 per cent increase from 1999 (see figure II). Globally, nearly 23 per cent of all people living with HIV are younger than age 24, and people age 15-24 account for 35 per cent of all people becoming newly infected. Sub-Saharan Africa remains the most severely

affected region, accounting for 68 per cent of all people living with HIV, 69 per cent of new infections and 72 per cent of AIDS deaths. The epidemic, however, has not spared other regions; more than 10.8 million people are living with HIV outside sub-Saharan Africa. It continues to deepen poverty, increase hunger, slow progress on maternal and child health and exacerbate other infectious diseases.

8. The epidemic particularly affects women and girls. In 2009, women represented a slight majority (about 51 per cent of all people living with HIV and about 60 per cent of all people living with HIV in sub-Saharan Africa). Adolescent girls and young women in sub-Saharan Africa are several times more likely to be living with HIV than males of the same age.

9. Although global HIV incidence has declined, the number of people acquiring infection remains on the rise in Eastern Europe and Central Asia, North Africa and the Middle East and parts of Asia. The often-cyclical nature of sexually transmitted epidemics underscores the need for continued vigilance, as prevention strategies must be reinforced and adapted as young people become sexually active.

Figure II
Estimated number of new HIV infections and deaths due to AIDS, 1990-2009



Source: *UNAIDS Report on the Global AIDS Epidemic 2010.*

10. With the number of people receiving antiretroviral therapy increasing 13-fold from 2004 to 2009, the number of AIDS-related deaths declined by 19 per cent during the same period. Still, the epidemic continues to exact severe consequences. From 2005 to 2009, the number of children orphaned by AIDS increased from 14.6 million to 16.6 million.

The 2001 and 2006 Declarations: a framework for unprecedented progress

11. The 2001 Declaration of Commitment on HIV/AIDS helped to galvanize global resolve to reverse the epidemic. Outcome indicators were established to monitor implementation of the targets adopted in 2001, with countries submitting biennial progress reports to the Joint United Nations Programme on HIV/AIDS (UNAIDS). Civil society and people living with HIV have played an especially critical role in tracking progress in implementing the 2001 and 2006 Declarations, evaluating national policy responses and contributing to country-specific reviews.

12. The endorsement of the goal of universal access in 2006 substantially accelerated global momentum. More than 110 countries established clear, time-bound national targets for service coverage. Although most countries are unlikely to have met their targets for 2010, advances over the last decade definitively demonstrate that universal access is both feasible and essential for long-term success.

III. Towards a world with zero new HIV infections, zero discrimination and zero AIDS-related deaths

13. Accomplishments to date have been genuine and often historic, but the pace and reach of scaling up remains inadequate. The response needs to be transformed. In 2010, UNAIDS articulated a new vision for the response, that of a world with zero new HIV infections, zero discrimination and zero AIDS-related deaths. This new vision is intentionally ambitious, reflecting the high aspirations of a people-centred global movement.

A. Zero new infections

14. Transforming the response requires changing working methods in order to radically reduce the number of people newly infected. Although global HIV incidence is now declining, many countries have failed to satisfy prevention commitments. As a result, the epidemic continues to outpace the response, with two people newly infected for every individual who started antiretroviral therapy in 2009.

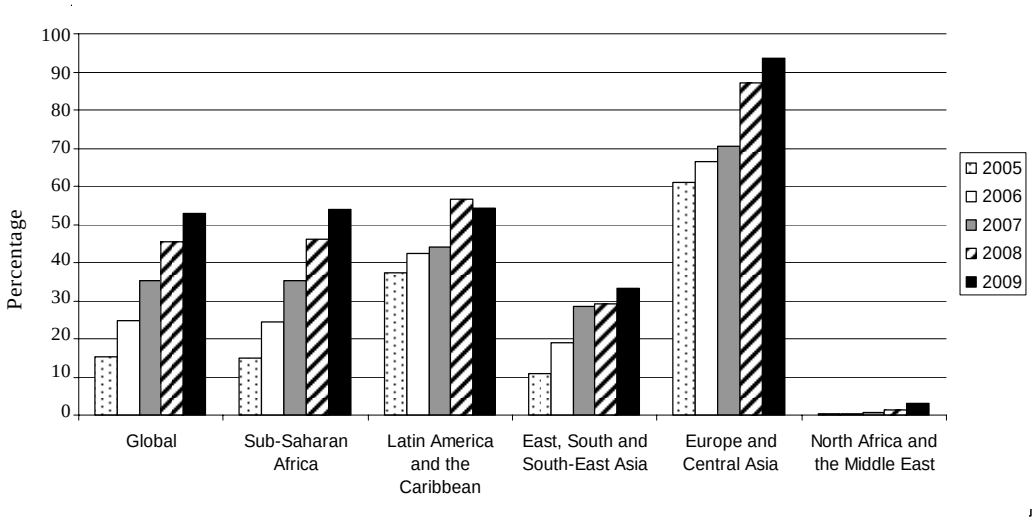
15. The 2001 Declaration declared HIV prevention to be the “mainstay of the response”, yet national policy frameworks and spending priorities do not adequately reflect this commitment. Although 91 per cent of countries have established treatment targets, only 33 per cent have HIV prevalence targets for young people and only 34 per cent have specific goals in place for condom programming.

16. Too often, national prevention strategies consist of fragmented and disconnected programmes without clearly defined causal pathways, articulated synergies or target outcomes. In Asia, 90 per cent of prevention resources for young people support programmes focused on low-risk youth, who account for only 5 per cent of the people acquiring HIV infection. Similarly, in Eastern Europe and Central Asia, where epidemics are primarily concentrated among people who use drugs, 89 per cent of prevention investment fails to focus on the people at highest risk.

Progress in preventing vertical transmission

17. In recent years, a growing number of countries have laid the foundation for eliminating vertical transmission (see figure III). As at December 2009, 15 countries had achieved the target set in the 2001 Declaration of at least 80 per cent coverage of antiretroviral prophylaxis among pregnant women living with HIV, and an additional seven countries in sub-Saharan Africa reported coverage between 50 per cent and 80 per cent. Countries in Eastern Europe and Central Africa have achieved especially high coverage. As a result of scaled-up prevention services, the number of children newly infected declined by 24 per cent globally from 2004 to 2009.

Figure III
Coverage of antiretroviral drugs for preventing vertical transmission of HIV in low- and middle-income countries, globally and by geographical region, 2005-2009



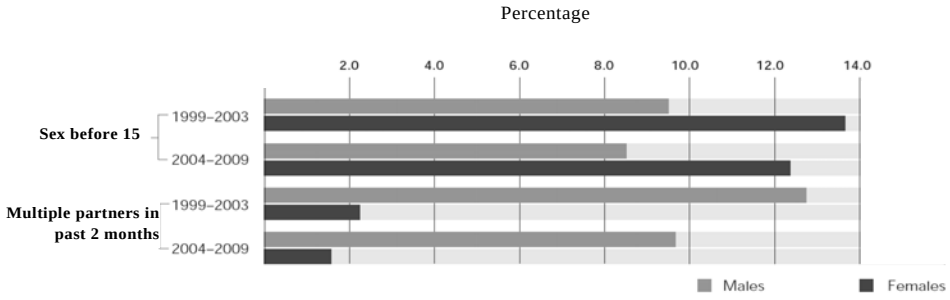
Source: WHO, UNAIDS and UNICEF, *Towards Universal Access: Scaling Up Priority HIV/AIDS Interventions in the Health Sector — Progress Report 2010.*

18. Eliminating vertical transmission requires far greater, and more rapid, advances to increase coverage and administer more effective regimens. Enhanced efforts are required to integrate HIV testing into antenatal services, since only 26 per cent of pregnant women in low- and middle-income countries were tested in 2009. Services to prevent mother-to-child transmission need to be more closely linked to sexual and reproductive health care. In 2009, 30 per cent of recipients of prevention services in antenatal settings received a suboptimal single-dose antiretroviral regimen, highlighting the importance of improving access to more efficacious combination regimens.

Encouraging trends among young people

19. Young people are leading the global prevention revolution. Among countries in which adult HIV prevalence exceeded 2 per cent, eight reported statistically significant declines in the percentage of girls who had sex before age 15, with seven countries reporting significant declines in early sexual debut among boys (see figure IV). Young people also show favourable trends in condom use (in 6 countries for young women and in 5 countries for young men) and number of sex partners (in 7 countries for young women and in 10 countries for young men). Although HIV-related knowledge among young people has increased, only 34 per cent of young people demonstrated accurate and comprehensive knowledge of HIV in 2009, well below the 95 per cent target identified in the 2001 Declaration of Commitment. Concerted action can address such knowledge deficits, as numerous countries — including Belarus, Chile and Eritrea — have demonstrated the feasibility of achieving rates of HIV-related knowledge exceeding 70 per cent among young people.

Figure IV
Young people and sexual risk: Proportion of people age 15-25 who had sex before age 15 and who had multiple partners in the past 12 months



Source: *UNAIDS Report on the Global AIDS Epidemic 2010.*

20. The 2001 Declaration called for expanded access to essential commodities, including male and female condoms. Although universal condom access has not been achieved, a clear trend towards increased availability and use during higher-risk sex is apparent.

Inadequate attention to the prevention needs of key populations at higher risk

21. The world will not be able to sharply lower the rate of HIV transmission without paying attention to the prevention needs of key populations at higher risk of exposure. However, as at 2009, only 26 per cent of countries had established prevention targets for sex workers, 30 per cent for people who used drugs and 18 per cent for men who had sex with men. Most countries do not report data on these key populations; many have little understanding of their size, age and geographical distribution. Resources allocated for prevention services for these groups are often minimal or non-existent. Other key populations that require heightened prevention support include prisoners, migrants, transgender people and people with disabilities.

22. According to data from 27 countries, only 32 per cent of people who injected drugs accessed HIV prevention services in 2009. In most countries surveyed in 2010, neither needle or syringe programmes nor long-acting opioid agonist therapy was available to reduce HIV transmission associated with drug use.

Making combination prevention a reality

23. To revolutionize HIV prevention, countries need to ground their national programmes in a thorough understanding of their epidemic and their response. Increasingly, countries are basing prevention strategies not on an understanding of the total number of people living with HIV (HIV prevalence), but rather on an improved understanding of the people newly infected with HIV (HIV incidence). As a result, a number of countries have taken steps to revise their prevention approaches to address emerging challenges and focus limited resources where they will have the greatest impact.

24. Combination prevention has been bolstered by the emergence of important new prevention tools, such as adult male circumcision, which reduces the risk of female-to-male sexual transmission by about 60 per cent. In 13 countries with high HIV prevalence and low prevalence of male circumcision, national situation

assessments have been conducted and strategic plans for scaling up circumcision developed. During the past two years, more than 200,000 men were circumcised in these 13 priority countries, including more than 90,000 in the Nyanza Province of Kenya alone.

25. Behavioural and biomedical approaches need to be supplemented with efforts that address the underlying social determinants of risk and vulnerability. In 2010, two studies in sub-Saharan Africa supported by the World Bank found that cash payments, contingent on adherence to recommended behaviour (such as staying in school or avoiding unprotected sex), reduced young people's risk of becoming infected with HIV or another sexually transmitted infection.

Emergence of critical new biomedical strategies for HIV prevention

26. During the past year, additional biomedical strategies have emerged to reduce the likelihood that any single sexual act will result in HIV transmission. In 2010, clinical trial results demonstrated that a vaginal microbicide could reduce a woman's risk of becoming infected during sexual intercourse. Additional trials are under way to confirm these results and to evaluate other microbicide candidates. If confirmed, these findings will help close a critical gap in the prevention toolkit: an effective prevention method that women may initiate on their own.

27. Also in 2010, a multi-country study found that a daily tablet containing the antiretroviral drugs tenofovir and emtricitabine reduced the risk of infection among men who had sex with men by 44 per cent. As in the case of microbicides, other trials are being conducted to confirm these results, including trials involving heterosexual cohort studies.

28. Each of these biomedical prevention advances involves unique and complex challenges. Additional studies are required to optimize acceptability, enhance adherence to prescribed protocols, monitor the risk of viral resistance in case of seroconversion and determine optimal service delivery models. National decision makers should expedite the integration of validated new tools into prevention programmes, where indicated, to increase the viability and sustainability of combination prevention efforts.

29. The search also continues for a preventive vaccine. Researchers have identified multiple antibodies that appear to neutralize HIV, providing important new avenues for vaccine development.

Integrating prevention and treatment

30. As the 2006 Political Declaration on HIV/AIDS emphasized, prevention, treatment, care and support are mutually reinforcing and must be closely linked. Emerging evidence of the important prevention benefits of antiretroviral therapy, which lowers viral load and thereby reduces the infectiousness of people living with HIV, merely underscores the need to link prevention and treatment efforts.

31. Separate planning approaches, however, are often undertaken for prevention and treatment. Little integration occurs at the level of service delivery. Referral systems for people who test HIV-positive are frequently fragmented and unmonitored. Prevention interventions have not been fully integrated in many clinical sites and about half of pregnant women testing HIV-positive in 2009 were not assessed for their eligibility to receive antiretroviral therapy. To strengthen links between prevention and treatment and to empower people living with HIV in prevention efforts, civil society partners joined with UNAIDS to call for

implementation of a strategy known as “positive health, dignity and prevention”. This strategy integrates prevention efforts into a holistic approach that takes account of the treatment needs and human rights of people living with HIV.

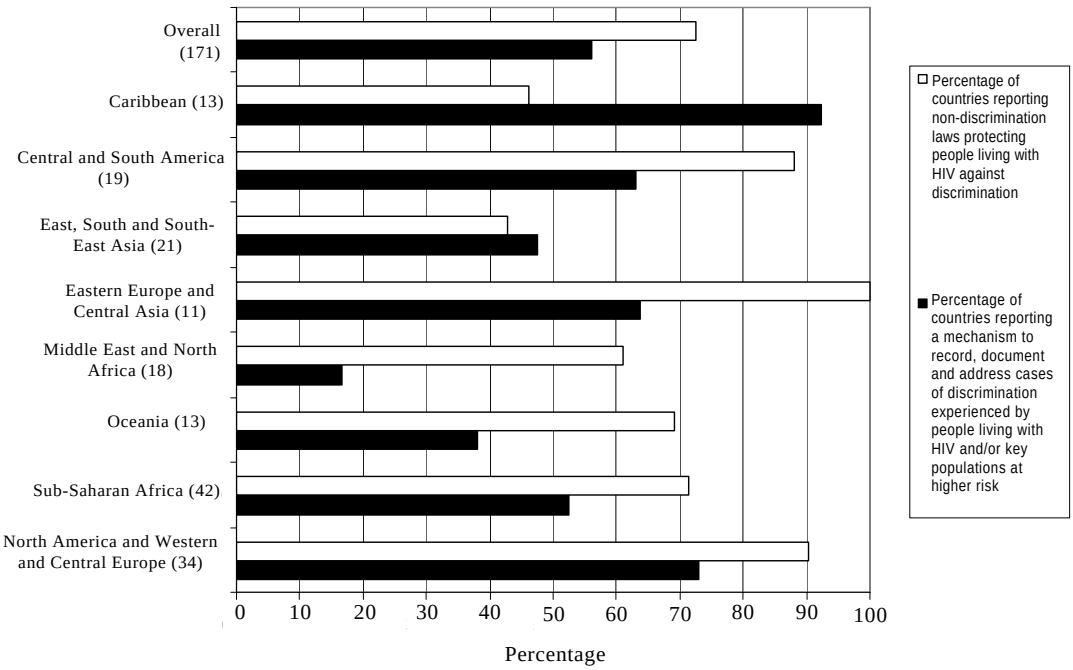
B. Zero discrimination

32. Thirty years after the epidemic was initially recognized, human rights violations continue to prevent open and compassionate discussion of the HIV challenge, deter individuals from seeking needed services, and increase individual vulnerability. An international survey of people living with HIV in 2010 found that more than one third had experienced loss of employment, denial of health care, social or vocational exclusion and/or involuntary disclosure. Globally, Governments cite stigma as the single greatest impediment to accelerated progress in the response. Social attitudes need to be transformed, and resources must be allocated to anti-stigma strategies and other initiatives to promote and protect human rights.

Inadequate protection against discrimination

33. The 2001 Declaration called on all Member States to have in place strong, enforceable measures to eliminate discrimination against people living with HIV or vulnerable groups. Although the number of countries reporting anti-discrimination laws in place increased from 56 per cent in 2006 to 71 per cent in 2010 (see figure V), it is disturbing that nearly 3 in 10 countries still lack such laws or regulations.

Figure V
Percentage of countries with legal protections against discrimination for people living with HIV and mechanisms for redress, as reported by non-governmental sources



Source: *UNAIDS Report on the Global AIDS Epidemic 2010.*

34. When anti-discrimination provisions are in place, they are often not effectively enforced. Globally, fewer than 60 per cent of countries report having a mechanism to record, document and address cases of HIV-related discrimination. In many countries, people living with HIV are at high risk of losing their homes, employment, property and inheritance due to inadequate protection.

35. In 2010, the vast majority of countries (91 per cent) addressed stigma and discrimination in their national HIV strategies, and 90 per cent of countries reported anti-stigma activities. However, most countries have no budget for anti-stigma activities.

36. Forty-nine countries, territories and entities impose some form of restriction on the entry, stay and residence of people living with HIV. Recent progress in this area is encouraging, as China, Namibia, Ukraine and the United States of America have repealed their respective HIV-based travel restrictions.

Discrimination against key populations at higher risk

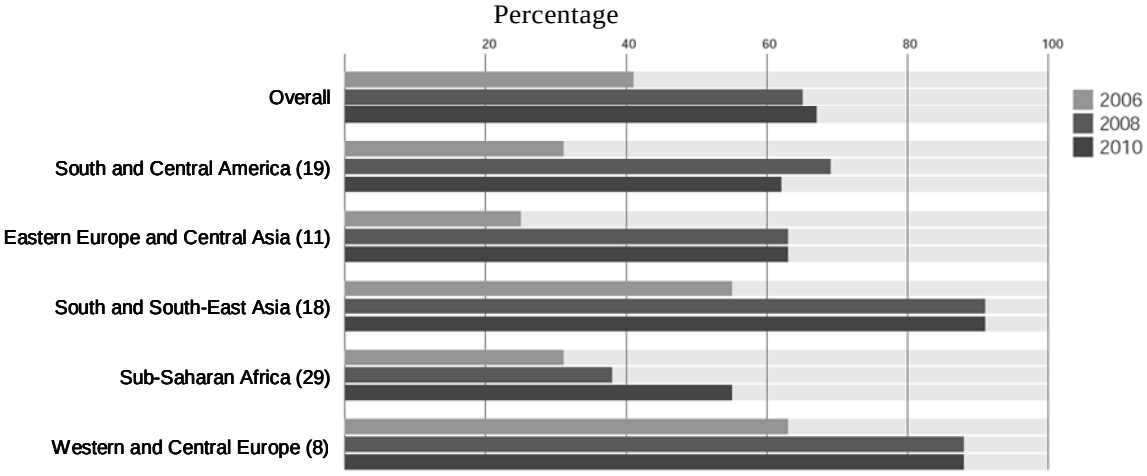
37. Punitive laws and practices also undermine the response. Dozens of countries criminalize HIV transmission, including more than 20 that have enacted such laws in recent years. These laws stigmatize people living with HIV and key populations at higher risk without promoting public health goals.

38. Seventy-nine countries and territories criminalize same-sex sexual relations between consenting adults, and more than 100 countries criminalize aspects of sex work. In settings throughout the world, fear and social disapproval increase the vulnerability of mobile populations, prisoners, adolescents who practice high-risk behaviour and people in humanitarian settings. Such discrimination deepens social marginalization, increases the risk of harassment or violence and inhibits communities from mobilizing to address the epidemic.

39. Discriminatory policies also reduce access to essential prevention and treatment services. Among 106 countries, non-governmental sources in 62 per cent of countries reported that laws, regulations or policies were in place diminishing access to services for key populations at higher risk (see figure VI).

Figure VI

Percentage of countries in which non-governmental sources report laws or regulations that create obstacles to effective HIV prevention, treatment, care and support for population groups at higher risk and other vulnerable populations, 2006-2010



Source: *UNAIDS Report on the Global AIDS Epidemic 2010.*

Note: The following regions are not displayed owing to insufficient countries: Caribbean, Middle East and North Africa, East Asia, Oceania and North America.

40. Strong leadership helps overcome the legacy of discrimination. Recent years have witnessed the expansion of prevention programmes for men who have sex with men in China, the scaling up of community-centred services targeted for sex workers in India and the decision by a growing number of countries to remove restrictions on harm reduction programmes for people who use drugs.

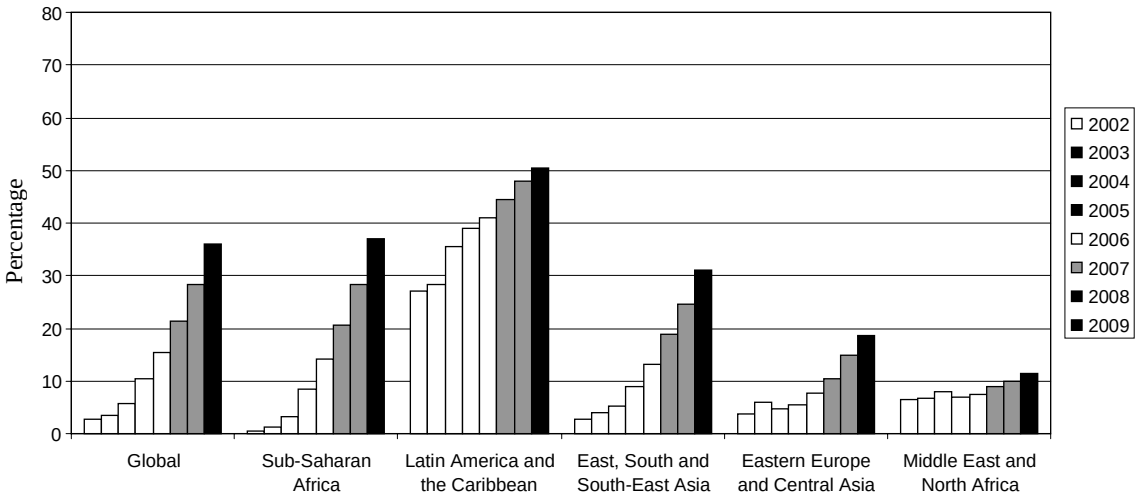
C. Zero AIDS-related deaths

41. Despite recent progress, nearly two in three people who are eligible for therapy still lack access. Transforming the response requires delivering life-preserving therapies to the people who need them, as well as new treatment, care and support approaches that are more sustainable.

Coverage is increasing but still inadequate

42. Recent gains in access to treatment are unprecedented (see figure VII). By the end of 2009, eight low- or middle-income countries were providing antiretroviral therapy to at least 80 per cent of the people eligible for treatment. Striking gains have been made in Eastern and Southern Africa.

Figure VII
Antiretroviral therapy coverage in low- and middle-income countries, globally and by region, 2002-2009



Source: WHO, UNAIDS and UNICEF, *Towards Universal Access: Scaling Up Priority HIV/AIDS Interventions in the Health Sector — Progress Report 2010.*

43. Yet these advances have failed to keep pace with the global need for treatment. About 10 million people who could benefit from treatment were not receiving it in 2009.

The quest for equitable access to treatment

44. Globally, treatment coverage is notably lower for children (28 per cent) than for adults (37 per cent). Historically, children's poorer access to treatment stemmed from the shortage of antiretroviral formulations for children, difficulties in diagnosing HIV among infants and the higher cost of drugs for children. An array of cost-effective antiretroviral formulations for children are now available, and improved technology permits rapid HIV diagnosis.

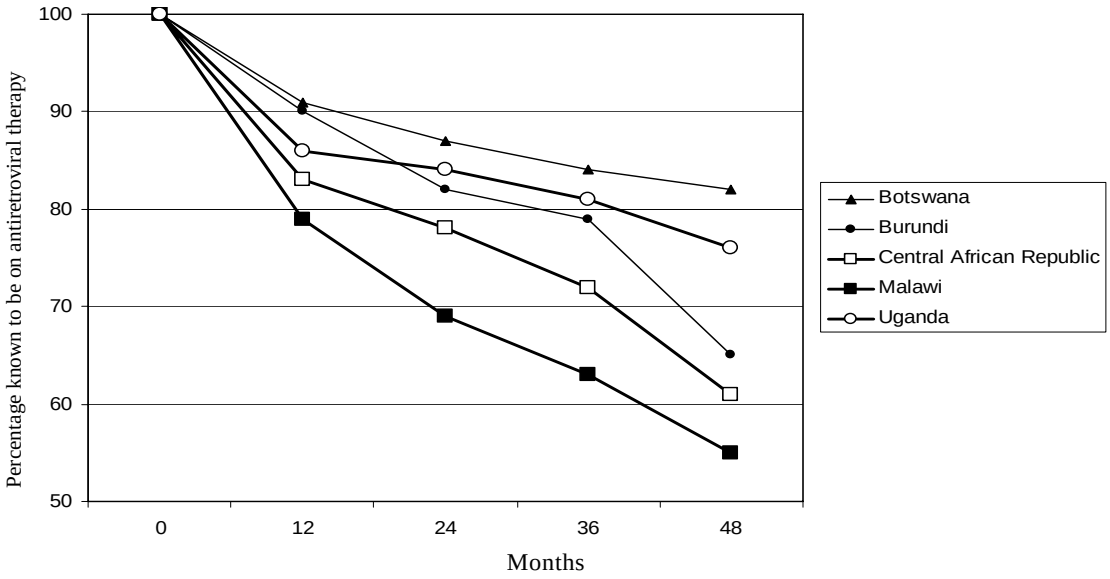
45. Marginalized populations also struggle to obtain equitable access to treatment, in part as a result of the hostility of many health-care workers. Among 21 countries reporting data on antiretroviral treatment utilization among people who injected drugs, 14 countries reached fewer than 5 per cent of such individuals.

Timely diagnosis and continuity of care

46. Although HIV testing has increased in recent years, fewer than 40 per cent of people living with HIV were aware that they were infected in 2009. Adolescents have special difficulty in accessing testing services, and globally, only 6 per cent of babies born to women living with HIV are tested. In numerous countries, testing rates have sharply risen following implementation of provider-initiated testing and counselling, intensive national campaigns and mobile testing initiatives.

47. Maintaining health-care continuity is essential to favourable medical outcomes for people living with HIV. In 26 low- and middle-income countries, at least 95 per cent of all individuals who initiate antiretroviral therapy continue receiving treatment after one year. However, many countries report significantly lower retention rates (see figure VIII), including one in which fewer than half of the people who started antiretroviral therapy remained on it one year later.

Figure VIII
Adult retention in antiretroviral therapy in selected countries, 0-48 months, 2009



Source: WHO, UNAIDS and UNICEF, *Towards Universal Access: Scaling Up Priority HIV/AIDS Interventions in the Health Sector — Progress Report 2010.*

48. Several factors impede treatment uptake and contribute to dropout. These include inadequate or non-existent transport to distant clinical sites, insufficient support services, side effects associated with suboptimal treatment regimens, out-of-pocket expenses for non-drug components of treatment services, opportunity costs (such as lost income) associated with clinic attendance and inadequate human resources for health.

Management of tuberculosis and other co-occurring conditions

49. Tuberculosis remains a leading cause of death among people living with HIV. A more integrated approach to the delivery of HIV and tuberculosis services improves health outcomes and reduces service costs. The UNAIDS strategy for 2011-2015 and the Global Plan to Stop TB aim to reduce by 50 per cent the number of tuberculosis deaths among people living with HIV compared with 2004 through enhanced service collaboration.

50. Significant advances have been made in managing HIV and tuberculosis coinfection, but enormous gaps remain. In 2009, 26 per cent of people with tuberculosis were tested for HIV — up from 4 per cent in 2003, but far from

adequate. Fifty-five countries reported testing at least 75 per cent of all people with tuberculosis for HIV in 2009, many of them in African countries with a heavy HIV burden. Among the 450,000 people with tuberculosis who tested HIV-positive in 2009, only 37 per cent received antiretroviral therapy. An even greater access gap was reported for tuberculosis screening, with only 5 per cent of people living with HIV screened for tuberculosis. Only 0.2 per cent of people living with HIV received isoniazid preventive therapy.

51. The 2001 Declaration called for implementation of strategies to deliver comprehensive care to people living with HIV. Since people with HIV live longer as a result of treatment advances, cancers and other disorders associated with ageing are likely to become more prominent in HIV clinical settings, underscoring the need for preparedness to provide holistic care and support.

Care and support for children orphaned or made vulnerable by HIV

52. The 2001 Declaration committed Member States to implement policies to provide a supportive environment to orphans and vulnerable children, including access to schooling, shelter, proper nutrition and health and social services. In hyperendemic countries, HIV is responsible for more than one in three orphans. Although social protection initiatives improve HIV outcomes for children, too few children receive any form of external support free of charge. In a number of countries, the proportion of households with children orphaned or made vulnerable by AIDS receiving basic support actually declined from 2005 to 2010. Many efforts to address children's needs remain small-scale, even though more than 16 million children worldwide have been orphaned due to AIDS and millions more experience daily vulnerability as a result of the epidemic.

53. To strengthen the safety net for children affected by the epidemic, several countries have taken steps to implement social cash transfer programmes for vulnerable households. Countries that have expanded access to cash assistance for households with vulnerable children include Gabon, Malawi, Namibia and Zambia.

IV. Cross-cutting issues

54. Achieving the vision of a world with zero new HIV infections, zero discrimination and zero AIDS-related deaths requires substantially greater progress across a range of cross-cutting issues.

Gender equality and the empowerment of women and girls

55. Revolutionizing HIV prevention requires concrete progress towards gender equality. This priority is especially imperative in sub-Saharan Africa, where 76 per cent of all women living with HIV reside and where 13 women become infected for every 10 men.

56. This imbalance reflects not only the heightened physiological vulnerability of girls and young women, but also a high prevalence of intergenerational partnerships, lack of woman-initiated prevention methods and broader social and legal inequality that impedes the ability of young women to reduce their sexual risk. Women's odds of living with HIV are inversely correlated with educational attainment, a fact that highlights the role of universal education initiatives in reducing HIV-related

vulnerability. Women also bear a disproportionate share of the HIV-related caregiving burden and are often more likely to be the victims of discrimination.

57. Despite the epidemic's enormous toll on women and girls, fewer than half of countries provide a specific budget for HIV-related programmes for women and girls. The prevalence of gender-based violence is as high as 50 per cent in some countries, with one of four women in sub-Saharan Africa reporting that their first sexual experience was coerced. Few programmes are in place to engage men and boys in efforts to eliminate gender-based violence and inculcate healthier gender norms. Zero tolerance of gender-based violence must be a shared goal.

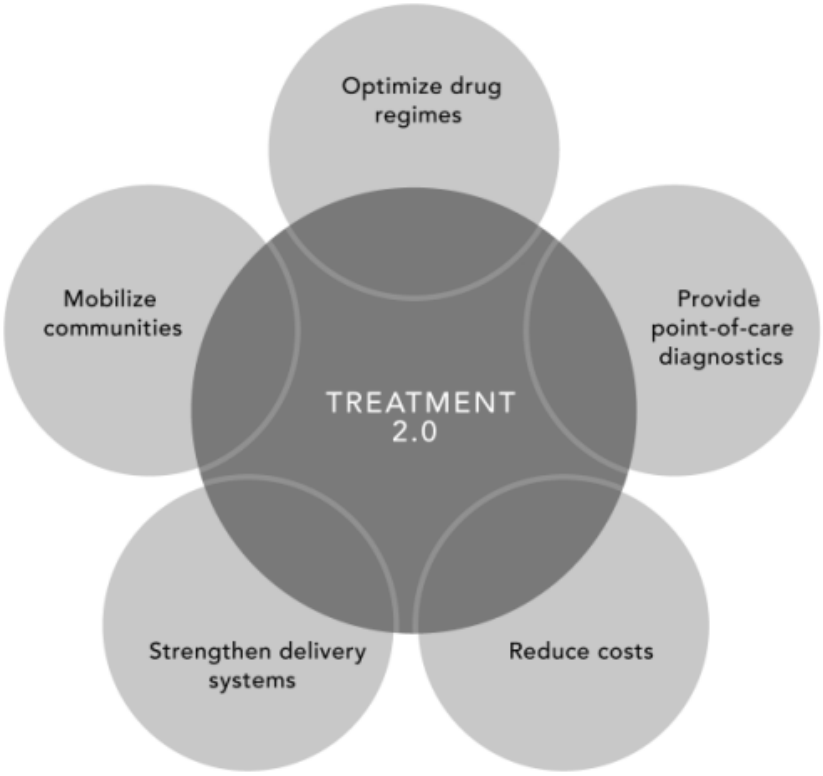
Robust and sustained financing for the response

58. Only a collective sense of shared responsibility and accountability will ensure that the response has sufficient resources in future years. In 2009, low- and middle-income countries accounted for 52 per cent of HIV expenditure. However, many low-income countries remain almost wholly dependent on external support.

59. Many countries, including some with severe and growing epidemics, have not given the response the priority it deserves. Middle-income countries, in particular, should cover their own HIV-related costs, with the possible exception of a few hyperendemic countries that will need continued assistance. Low-income countries will remain largely dependent on international AIDS assistance in future years, highlighting the need for more effective use of resources, streamlined donor reporting requirements, alignment with national strategies and institutions and more predictable funding. However, even low-income countries have an important role to play in funding and taking ownership of their response. Long-term financing for the response highlights the urgent need for sustained support to the Global Fund.

60. As efforts are made to mobilize new resources for the response, intensified attention must focus on maximizing the efficient use of available resources. The Treatment 2.0 approach, a new treatment platform launched by UNAIDS in 2010 (see figure IX), aims to optimize the long-term benefits of HIV treatment while implementing measures to increase efficiency.

Figure IX
Five pillars of Treatment 2.0



61. Lowering the costs of HIV commodities is critical. The number of countries that allow for flexibilities in intellectual property rules has declined in recent years, and a growing array of bilateral and regional trade agreements are undermining the ability of countries to maximize these flexibilities to promote access to essential medicines.

Building sustainable capacity

62. Both the 2001 and 2006 Declarations recognize the importance of strengthening systems. The challenges the epidemic poses to fragile health systems are especially evident in sub-Saharan Africa, home to more than two of three people living with HIV, but to only 3 per cent of the world's health-care providers. There are encouraging signs of resilience as health systems struggle to cope with the epidemic's demands. The number of health facilities administering antiretroviral therapy rose by 36 per cent from 2008 to 2009. Studies indicate that HIV programmes are conferring broad benefits on health systems, refurbishing clinics, strengthening commodity procurement and supply management and building national capacity for monitoring and evaluation.

63. Underlying weaknesses in health systems continue to undermine efforts to expand service access. Of 94 countries reporting, 38 per cent had at least one drug stock out in 2009. Current models for expanding treatment, which are heavily hospital- and physician-intensive, strengthen the effects of health worker shortages

and underscore the need for greater task-shifting of clinical duties to lower-level staff. Studies confirm that the greater use of nurses, mid-level staff and lay workers in antiretroviral therapy settings may enable excellent, and sometimes even superior, health outcomes. Similar innovations are needed in delivering prevention services.

64. Although community leadership and service delivery will be pivotal to future success, many communities lack the capacity to optimize their contributions to national responses. Donors should provide the resources and technical support that communities need, including adequate compensation for work performed, and national Governments must ensure that communities are full partners in developing, implementing and monitoring AIDS strategies. Increased support is also needed to strengthen national social protection systems to improve efforts to mitigate the impact of the epidemic.

Expanding the evidence base for action

65. Robust research efforts are needed to accelerate the drive to discover a cure, develop a safe and effective vaccine, expedite the emergence of additional new prevention technologies and better understand and address underlying vulnerability. Focused studies are required to expedite the introduction of new prevention tools, identify more effective strategies to increase HIV testing, link individuals who test HIV-positive to continuous, high-quality care and increase medication adherence rates. Particular efforts are required to increase support for community-generated studies and the documentation of best practices.

Integrating the response in broader health and development efforts

66. The synergy between HIV and other health and development priorities needs to be maximized. An estimated 260,000 children died from AIDS-related causes in 2009, and HIV is a key factor in an estimated 20 per cent of all maternal deaths. HIV deepens poverty, exacerbates hunger and contributes to higher rates of tuberculosis and other infectious diseases. Conversely, progress on other development priorities, such as universal schooling, gender equality and health system strengthening, helps bolster HIV responses. Achieving this synergy requires integrating HIV within the broader development agendas at the levels of strategic planning, service delivery, advocacy and partnership cultivation.

HIV and security

67. Significant changes have occurred in the landscape of demographic crises and conflicts. Evolving challenges and new risks elevate the need for strengthened HIV responses in the context of efforts of the United Nations to prevent conflict, promote security, strengthen fragile States and build peace. A new course of action is needed that mobilizes the millions of members of uniformed services as important agents of change — especially in combating all types of violence against women — and aligns strategies for HIV prevention with conflict, post-conflict and peacebuilding operations.

V. A call to action: five recommendations

68. At this pivotal juncture, it is necessary to dramatically reshape the HIV response to reach zero new HIV infections, zero discrimination and zero AIDS-

related deaths. This requires rejuvenated political leadership for more focused, efficient and sustainable responses that are aligned with broader health, development and human rights agendas.

69. The Secretary-General calls on all leaders to take advantage of this turning point in the epidemic: an AIDS transition that sees fewer people newly infected than those who start receiving treatment is an attainable target. The international community must intensify its efforts if it is to achieve, by 2015, universal access to HIV prevention, treatment, care and support and other unmet targets of the 2001 Declaration of Commitment on HIV/AIDS and the 2006 Political Declaration on HIV/AIDS, and to implement the action agenda of the 2010 outcome document entitled "Keeping the promise: united to achieve the Millennium Development Goals" (see General Assembly resolution 65/1).

70. Every aspect of the response must reflect a shared commitment to transformative social change for health, development and human rights. It must incentivize leaders to take bold action to bring about such change. It must be ensured that the HIV response is sustained as a political priority, taken out of isolation and leveraged to reinforce the social fabric of our societies. It must strengthen the systems that deliver critical services to the most vulnerable and marginalized members of our communities.

A. End new HIV infections

71. Ending new infections will require responding to a fast-changing world, which is marked increasingly by urbanization, human mobility and insecurity. Thirty years into the epidemic, HIV prevention and treatment efforts are increasingly unified to more efficiently achieve the shared outcomes of fewer new infections and fewer people dying. Putting people living with HIV at the centre of the response is therefore critical. It must be recognized that inclusion, non-discrimination, pragmatism and compassion will yield benefits not only for the HIV response but also across health, development and human rights priorities.

72. The Secretary-General therefore calls on all Member States, civil society, the private sector and other actors to champion a prevention revolution that harnesses the energy of young people and the potential of new modes of connection and communication that are transforming the world, that rescinds punitive laws that block effective responses and ensures people are empowered to protect themselves, their partners and their families from HIV by undertaking the following actions:

(a) Commit to averting the maximum number of HIV infections for each dollar spent by focusing evidence-informed and rights-based efforts on the populations that account for the largest share of new infections and by saturating transmission hot spots with proven interventions such as female and male condom promotion, male circumcision, treatment as prevention, harm reduction for drug users and "Positive health, dignity and prevention" approaches that link the social and health needs of people living with HIV within a human rights framework;

(b) Ensure that legal, political and social environments enable effective HIV responses — including through protective laws, supportive law enforcement and access to justice — to eradicate HIV-related stigma and discrimination and to enable equitable access to HIV-related information and services, especially for people who

use drugs, men who have sex with men, people who buy and sell sex, young people and populations affected by humanitarian situations;

(c) Scale up research investments to accelerate the development of vaccines, female-controlled methods, microbicides and other prevention tools, and enhance collaboration among scientists, the private sector, Governments and communities to expedite the introduction of, and equitable access to, validated new tools as they emerge.

B. Share responsibility and build ownership for sustainable outcomes

73. While some $16 billion was available for the global response in 2010, a significant gap remains between investment needs and available resources, and the gap is widening. It is imperative to ensure the sustainability of efforts, including protecting access for the more than 6 million people receiving treatment in low- and middle-income countries and ensuring access for the millions who are still in need. Countries must commit to global solidarity, built on the tenets of shared responsibility, true national ownership and mutual accountability. The global South must exercise greater leadership in the governance of AIDS responses at all levels. Let the AIDS response be a beacon of global solidarity for health as a human right and set the stage for a future United Nations framework convention on global health.

74. The Secretary-General therefore calls on Member States, and all actors in the response to HIV, to undertake the following actions in forging a revitalized framework for global solidarity to reach universal access to HIV prevention, treatment, care and support by 2015:

(a) Exercise inclusive and accountable leadership, and create space for national debate on priorities, strategic investments, social protection and legal measures to foster broad ownership and access to entitlements, ensuring that people living with and vulnerable to HIV — young and old — are able to act as partners in the governance, design, delivery and evaluation of the response;

(b) Meet fair-share commitments to reach investment needs, whereby international donors realize their long-term, predictable financing commitments and domestic investment in low- and middle-income countries is significantly scaled up, emerging political and economic powers assume their share in international and regional leadership for the AIDS response, and innovative financing mechanisms are expanded;

(c) Actively support and strengthen the capacity of national institutions, community systems and human resources for health to mount evidence-informed and rights-based responses, including by promoting South-South cooperation and using regionally sourced technical support.

C. Break the upward trajectory of costs

75. National responses must move from crisis management to change management. Success depends on focusing resources on actions that will generate results and efficiency while promoting country- and people-owned responses. Strengthening national and community institutions and democratizing problem-

solving will result in more locally appropriate, broadly owned responses and client-centered care at lower costs, and this will drive long-term sustainability.

76. The Secretary-General therefore urges Governments, civil society, the private sector and other actors to commit to the following actions to break the upward trajectory of costs and to deliver more efficient and sustainable programmes:

(a) Catalyse efficiency-generating innovation in treatment access, including through the Treatment 2.0 agenda, by fostering development, in cooperation with the pharmaceutical industry, of more affordable, more resilient, less toxic, longer-acting and easier-to-use drug regimens, by significantly scaling up access to point-of-care diagnostics and clinical monitoring tools, by supporting countries in taking full advantage of the flexibilities inherent in the Doha Declaration on the TRIPS Agreement and Public Health and ensuring that other trade agreements do not undermine these flexibilities, by expanding patent pools, and by enhancing access to all essential medicines at sustainable prices;

(b) Maximize efficiency in non-drug-related costs, including by decentralizing services, task-shifting and building the capacity of community health workers, and strengthening community systems and rights-based approaches in service delivery;

(c) Work with partners to ensure that synergies are exploited between the HIV response and efforts to achieve the Millennium Development Goals, including by scaling up efforts to coherently address HIV and tuberculosis coinfection, by leveraging the AIDS response to improve maternal, child and sexual and reproductive health outcomes, and by integrating HIV-related services with food and nutrition support and, where appropriate, services for chronic illnesses, including providing palliative care and addressing opportunistic infections, cardiovascular disease, diabetes and hepatitis C.

D. Foment a social revolution for women and girls

77. Gender inequality, harmful gender norms and violence compromise the ability of women and girls to protect themselves from HIV, and therefore fuel the epidemic. The establishment of UN-Women, as well as the UNiTE to End Violence against Women campaign, marks a new phase in the commitment of the United Nations and Member States to gender equality and empowering women. The HIV and women's movements must unite to empower women and girls, especially young women, to know and demand their rights, including protection from sexual coercion and violence and access to gender-sensitive and gender-transformative HIV-related programmes.

78. The Secretary-General therefore urges all stakeholders to ensure that the status of women and girls in our societies and our responses to HIV promote their health, human rights, security and dignity, including through the following actions:

(a) Take specific measures, from households to parliaments, to empower women and girls by reversing harmful gender norms, by ensuring that legal frameworks provide equal rights and equal access to justice and security for women and girls, by protecting the rights of women and girls living with HIV, including their sexual and reproductive health and human rights, by strengthening social protection, care and support programmes for children affected by AIDS, and by

scaling up programmes to eliminate gender-based violence as a cause and consequence of HIV that also engage men and boys;

(b) Ensure national responses meet the HIV-specific needs of women and girls across the span of their lives and actively confront and eradicate gender inequality-driven gaps in access to HIV-related information, services and commodities, including for women and girls affected by humanitarian situations;

(c) Support the Global Strategy for Women's and Children's Health and the UNAIDS Agenda for Accelerated Country Action for Women, Girls, Gender Equality and HIV in order to deliver a comprehensive, integrated HIV, tuberculosis and sexual and reproductive health package addressing the broader health needs of women and children, including orphans, leveraging services to prevent vertical HIV transmission as an entry point to deliver a range of services to women, children and families.

E. Ensure mutual accountability for universal access

79. Although sustained political commitment, human resources and financial support are essential for achieving universal access, they do not guarantee results. Robust systems of accountability are key to success. These must start with systems for data collection and analysis that result in policies and programmes tailored to populations; modes of transmission; geographical settings; and programmatic, legal and structural gaps in the response.

80. The Secretary-General therefore recommends that Member States, civil society and other stakeholders commit to forging robust mutual accountability mechanisms for the translation of commitments into action, through the following actions:

(a) Countries set ambitious national targets to fully achieve universal access based on "know your epidemic, know your response" methods; work with UNAIDS to develop a revised framework of core global indicators that respond to new global commitments and goals; mount periodic and inclusive evidence-informed and rights-based reviews of progress towards national targets; and, with the support of UNAIDS, submit a progress report to the Secretary-General in accordance with global reporting on the Millennium Development Goals at the special event of the General Assembly on the Millennium Development Goals in 2013 and subsequent Millennium Development Goal reviews;

(b) Establish annual peer-based regional reviews, organized by competent regional political bodies and with the support of the relevant United Nations regional commissions and UNAIDS, that facilitate the engagement of health and non-traditional yet key ministries such as justice, finance, public security and law enforcement;

(c) Identify substantive roles (such as co-chairing), as well as financial support for participation, in national and regional reviews for delegations of civil society and affected communities, including people living with HIV, people who use drugs, men who have sex with men, people who buy and sell sex and young people.

Global goals for 2015

In committing to the vision of zero new HIV infections, zero discrimination and zero AIDS-related deaths, the international community must hold itself accountable for reaching shared goals that will rewrite the future for generations. The UNAIDS strategy for 2011-2015 presents a number of ambitious goals to lead and galvanize the United Nations system, and the entire global response, to deliver transformative results.

In order to accelerate progress in all the goals set out in the UNAIDS strategy, commit to bringing about measurable impact on the lives of the people most affected and focus efforts on the most critical pillars of the response, the Secretary-General urges that the global community adopt the following goals for 2015:

(a) The prevention imperative is upon us. The human, social, economic and hence political costs of insufficient action will be extremely high. The Secretary-General therefore urges Member States to commit to reducing by 50 per cent sexual transmission of HIV — including among key populations, such as young people and men who have sex with men and in the context of sex work — and to preventing all new HIV infections as a result of injecting drug use;

(b) Global solidarity has brought treatment to more than 6 million people living with HIV. Through innovation, in drugs, pricing and delivery systems, it is possible to bring down costs, prevent new infections and achieve universal access to treatment. The Secretary-General therefore calls on Member States to ensure that 13 million people are receiving HIV treatment by 2015;

(c) Tuberculosis remains the leading cause of death among people living with HIV, despite being preventable and curable. The Secretary-General therefore calls on Member States to commit to reducing by 50 per cent tuberculosis deaths among people living with HIV;

(d) It is a grave global injustice that 370,000 newborns contract HIV in low- and middle-income countries each year, while vertical transmission has been virtually eliminated in high-income countries. The Secretary-General therefore calls on Member States to come together to eliminate vertical transmission of HIV, and in so doing, keep mothers alive, prevent children from becoming orphans and improve the health of women, children and families;

(e) Children continue to be severely impacted by the epidemic, with great demands placed on caregivers. Children who have lost both parents have less access to education than non-orphans. The Secretary-General therefore urges Member States to commit to ensuring that the most vulnerable children affected by AIDS are supported to stay in school, including through the creation of safe and non-stigmatizing learning environments and the expansion of social protection and care and support programmes for the most vulnerable families, with a target of equal education access between orphans and non-orphans by 2015;

(f) Institutionalized discrimination targeted at people living with HIV continues to undermine every effort made in the AIDS response. The Secretary-General therefore urges Member States to commit to reducing by 50 per cent the number of countries with HIV-related restrictions on entry, stay and residence.

81. It is the firm conviction of the Secretary-General that these six goals can be achieved. This conviction is based on the history of the AIDS response: a history marked by human courage and led by people living with HIV, which has refashioned human aspirations, transformed institutions and delivered remarkable results against inimitable odds.

82. The United Nations has played an important part in this history. UNAIDS continues to be at the centre of these efforts. In the midst of a proliferation of development efforts, UNAIDS has modelled United Nations reform in action and has united the global community around a shared agenda, conveying the demands of the people and catalysing commitment and action at all levels.

83. By working together to execute these recommendations, the international community can achieve these goals by 2015, and take an extraordinary and unified step towards a world of “zero, zero, zero”.

General Assembly

Distr.: General
30 March 2011

Sixty-fifth session
Agenda item 10

Resolution adopted by the General Assembly

[*without reference to a Main Committee (A/65/L.49)*]

65/180. Organization of the 2011 comprehensive review of the progress achieved in realizing the Declaration of Commitment on HIV/AIDS and the Political Declaration on HIV/AIDS

The General Assembly,

Reaffirming its commitment to the Declaration of Commitment on HIV/AIDS,[1] in which it decided, inter alia, to devote sufficient time and at least one full day of the annual session of the General Assembly to reviewing and debating a report of the Secretary-General,

Reaffirming also its commitment to the Political Declaration on HIV/AIDS,[2] in which it decided, inter alia, to undertake comprehensive reviews in 2008 and 2011, within the annual reviews of the General Assembly, of the progress achieved in realizing the Declaration of Commitment and the Political Declaration,

Recalling the HIV/AIDS-related goals and commitments contained in the United Nations Millennium Declaration,[3] in the 2005 World Summit Outcome[4] and in the outcome document of the High-level Plenary Meeting of the General Assembly on the Millennium Development Goals,[5]

Emphasizing the significance of the comprehensive review in 2011 which will mark three decades of the HIV/AIDS pandemic, the ten-year review of the Declaration of Commitment on HIV/AIDS and its time-bound measurable goals and targets, and the five-year review of the Political Declaration on HIV/AIDS with the goal of achieving universal access to comprehensive HIV prevention, treatment, care and support by 2010, while bearing in mind the fact that these goals and targets will expire at the end of 2010 and the urgent need to renew the political will for, and to continue fulfilling our commitments to, the global response to HIV/AIDS,

[1] Resolution S-26/2, annex.

[2] Resolution 60/262, annex.

[3] See resolution 55/2.

[4] See resolution 60/1.

[5] See resolution 65/1.

1. *Decides* to convene a high-level meeting from 8 to 10 June 2011, which will undertake a comprehensive review of the progress achieved in realizing the Declaration of Commitment on HIV/AIDS[1] and the Political Declaration on HIV/AIDS,[2] including successes, best practices, lessons learned, obstacles and gaps, challenges and opportunities, and recommendations to guide and monitor the HIV/AIDS response beyond 2010, including concrete strategies for action, as well as promote the continued commitment and engagement of leaders in a comprehensive global response to HIV/AIDS;

2. *Also decides* that the organizational arrangements for the high-level meeting should be as follows:

(*a*) The high-level meeting shall comprise plenary meetings and up to five thematic panel discussions;

(*b*) The opening plenary meeting shall feature statements by the President of the General Assembly, the Secretary-General, the Executive Director of the Joint United Nations Programme on HIV/AIDS, a person openly living with HIV and an eminent person actively engaged in the response to HIV/AIDS;

(*c*) The Chairs of the panel discussions shall present summaries of the discussions to the closing plenary meeting;

3. *Invites* Member States and observers to be represented at the highest level at the high-level meeting;

4. *Encourages* Member States to include in their national delegations to the high-level meeting parliamentarians, representatives of civil society, including non-governmental organizations and organizations and networks representing people living with HIV, women, young persons, orphans, community organizations, faith-based organizations and the private sector;

5. *Decides* that the Holy See, in its capacity as Observer State, and Palestine, in its capacity as observer, shall participate in the high-level meeting;

6. *Invites* the United Nations system, including programmes, funds, specialized agencies and regional commissions, the Special Envoys of the Secretary-General for HIV/AIDS and the Special Envoy of the Secretary-General to Stop Tuberculosis, as well as the Global Fund to Fight AIDS, Tuberculosis and Malaria, to participate in the high-level meeting, as appropriate, and urges them to consider initiatives in support of the preparatory process and the meeting;

7. *Encourages* other stakeholders, including the International Drug Purchase Facility, UNITAID, and the Partnership for Maternal, Newborn and Child Health, to contribute, as appropriate, to the high-level meeting;

8. *Invites* the Inter-Parliamentary Union to contribute to the high-level meeting;

9. *Requests* the President of the General Assembly to organize, no later than in April 2011, an informal interactive civil society hearing with the active participation of people living with HIV and broader civil society, and attended by representatives of Member States, the Observer State and observers, non-governmental organizations in consultative status with the Economic and Social Council, invited civil society organizations and the private sector, as part of the preparatory process for the high-level meeting;

10. *Decides* that the President of the General Assembly shall preside over the informal interactive hearing with representatives of non-governmental

organizations, civil society organizations and the private sector, and requests the President to prepare a summary of the hearing, issued as a document of the Assembly prior to the high-level meeting;

11. *Encourages* Member States to actively participate in the hearing at the ambassadorial level to facilitate interaction between Member States and representatives of non-governmental organizations, civil society organizations and the private sector;

12. *Invites* intergovernmental organizations and entities that have observer status with the General Assembly, non-governmental organizations in consultative status with the Economic and Social Council, and non-governmental members of the Programme Coordinating Board of the Joint Programme to participate in the high-level meeting, as appropriate;

13. *Decides* that representatives of non-governmental organizations in consultative status with the Economic and Social Council, civil society organizations and the private sector, one from each grouping, selected during the informal interactive hearing, may also be included in the list of speakers for the plenary meetings of the high-level meeting, in consultation with the President of the General Assembly;

14. *Requests* the President of the General Assembly, following appropriate consultations with Member States, to draw up, no later than 31 March 2011, a list of other relevant civil society representatives, in particular associations of people living with HIV, non-governmental organizations, including organizations of women and young people, girls and boys and men, faith-based organizations and the private sector, especially pharmaceutical companies and representatives of labour, including on the basis of the recommendations of the Joint Programme and taking into account the principle of equitable geographical representation, and to submit the list to Member States for consideration on a no-objection basis for a final decision by the Assembly on participation in the high-level meeting, including panel discussions;

15. *Decides* that the arrangements outlined in paragraph 14 above shall not be considered a precedent for other similar events;

16. *Requests* the President of the General Assembly, with support from the Joint Programme and in consultation with Member States, to finalize the organizational arrangements for the high-level meeting, including the identification of a person openly living with HIV and an eminent person actively engaged in the response to HIV/AIDS to speak at the opening plenary meeting, the identification of themes and finalization of the panel discussions, and the arrangements for the informal interactive hearing with civil society;

17. *Requests* the Joint Programme to continue facilitating, to the extent possible, inclusive consultations at the country and regional levels, with the participation of relevant stakeholders, including Governments, non-governmental organizations, civil society and the private sector, to review progress made towards universal access to HIV prevention, treatment, care and support, as well as opportunities to address gaps, obstacles and challenges;

18. *Requests* the Secretary-General to submit a comprehensive and analytical report, at least six weeks prior to its consideration by the General Assembly, on progress achieved and challenges remaining in realizing the commitments set out in the Declaration of Commitment and the Political Declaration, as well as recommendations for sustainable ways to overcome those challenges, taking into

consideration the outcomes and findings of the aforementioned universal access review consultations;

19. *Requests* the President of the General Assembly to hold timely, open, transparent and inclusive consultations with all Member States, with a view to adopting a concise and action-oriented declaration, as an outcome of the high-level meeting to be agreed by Member States, that reaffirms and builds on the Declaration of Commitment and the Political Declaration to guide and monitor the HIV/AIDS response beyond 2010, giving due consideration to the report of the Secretary-General and other inputs to the preparatory process for the high-level meeting.

69th plenary meeting
20 December 2010

United Nations A/65/835

General Assembly

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Sixty-fifth session
Agenda item 10
Implementation of the Declaration of Commitment on HIV/AIDS and the Political Declaration on HIV/AIDS

Informal interactive hearing of the General Assembly with representatives of non-governmental organizations, civil society organizations and the private sector on the 2011 High-level Meeting on HIV/AIDS

Note by the President of the General Assembly

The President of the General Assembly has the honour to transmit the summary of the informal interactive hearing of the General Assembly with representatives of non-governmental organizations, civil society organizations and the private sector, prepared pursuant to paragraph 10 of General Assembly resolution 65/180 (see annex).

11-33099 (E) 130511

Annex

Summary of the informal interactive hearing of the General Assembly with representatives of non-governmental organizations, civil society organizations and the private sector on the 2011 High-level Meeting on HIV/AIDS

Introduction

1. An all-day civil society hearing was held on 8 April 2011 at United Nations Headquarters. Presided over by the President of the General Assembly, the hearing aimed to inform preparations for the 2011 High-level Meeting on HIV/AIDS, including negotiations by Member States of an outcome document for the meeting.

2. Planned with the support of a civil society task force convened by the President of the General Assembly for purposes of preparing for the 2011 High-level Meeting, the hearing included an opening session, followed by three thematic sessions. Each moderated thematic session included brief comments by individual panellists, comments from designated civil society representatives and a question-and-answer session between the moderator and the panel.[1]

3. More than 400 civil society representatives participated in the hearing, including more than 100 individuals who either participated as panellists or made statements from the floor. The present report summarizes key outcomes of the day-long hearing, providing summaries of each session. The purpose of the summary is to provide Member States with a resource in their consultations on the outcome document for the High-level Meeting.

Opening session

4. Welcoming participants to the day-long hearing, the President of the General Assembly reminded attendees that five years had passed since the General Assembly embraced the ambitious goal of universal access to HIV prevention, treatment, care and support. The hearing had been convened not to reach decisions but rather to promote sharing of knowledge and best practices.

5. The Secretary-General expressed gratitude and recognition for the leadership of civil society in the HIV response. The report of the Secretary-General to the General Assembly for the High-level Meeting (A/65/797) urged endorsement of new goals for the response, including reducing HIV transmission by half by 2015, providing treatment to at least 13 million people by 2015, eliminating vertical transmission and sharply reducing the number of countries with punitive laws. The Secretary-General reminded participants of the global vision of a world with zero new infections, zero AIDS deaths and zero discrimination.

6. The Executive Director of the Joint United Nations Programme on HIV/AIDS (UNAIDS), advised that the HIV response was undergoing an important transformation, transcending a silo approach and linking more closely to other

[1] For background documents prepared for the hearing, see http://www.unaids.org/en/media/unaids/contentassets/documents/document/2011/20110408_CSH_Bgrd_en.pdf.

movements. Jeanne Gapiya-Niyonzima, founder of the Association nationale de soutien aux séropositifs et aux malades du SIDA in Burundi, emphasized the importance of continuing commitment in the HIV response, advising that there was no room for complacency and urging a strong working partnership between Governments and civil society.

Panel I: enhancing community level access: opportunities for healing social and systemic ills

7. The first panel focused on strategies to leverage community resilience and insight to address underlying issues that contribute to the epidemic's continued expansion. Speakers highlighted the urgent need for robust and predictable funding for civil society organizations to ensure meaningful community engagement in the response. Participants warned against the imposition on communities of service models and HIV strategies that are externally formulated and implemented by actors outside the community.

8. A key theme of the first panel was the critical importance of sufficient financial resources to sustain an effective response and to advance progress towards universal access to HIV prevention, treatment, care and support. Speakers emphasized the need for clear funding targets for the response, for intensified advocacy to encourage countries to make sufficient financial contributions and for maximized use of innovative financing mechanisms. The potential of innovative financing is evident in such instruments as the Global Fund to Fight AIDS, Tuberculosis and Malaria and UNITAID, which make major contributions to financing national responses even though they are underfunded.

9. Speakers stressed that without additional increases in funding for HIV programmes and improved efficiency in the use of resources, it would be impossible to achieve universal access. Universal treatment access is not only critical to saving the lives of people living with HIV, but treatment also lowers viral load and thereby supports efforts to prevent new infections. Treatment is an essential element of "combination prevention", which involves the strategic use of biomedical, behavioural and social/structural strategies. It was noted that effective use of therapies to address HIV/tuberculosis co-infection would dramatically reduce HIV-related morbidity and mortality. Speakers also emphasized the importance of comprehensive care and support, including psychosocial support, financial assistance and access to palliative care. Optimal and creative use of flexibilities in intellectual property regulations was cited as an essential element of a successful strategy to achieve universal access. In particular, speakers warned that bilateral trade agreements are increasingly being used to undermine both the availability of generic drugs and the freedom of countries to maximize access to essential medicines.

10. The need to focus HIV resources in a strategic manner was highlighted, as well as the importance of protecting against misuse of limited financing. In Asia, it was observed that roughly 90 per cent of prevention funding for young people is targeted at low-risk youth, with minimal financing for programmes focused on the young people at greatest risk of infection, such as sex workers, men who have sex with men and people who use drugs.

11. Speakers emphasized the pernicious effects of persistent stigma and discrimination, combined with the failure of national leaders to acknowledge the existence of key populations at higher risk. It was noted that throughout much of Eastern Europe and Central Asia, official resistance to evidence-informed harm reduction programmes continues to result in avoidable HIV infections and needless human suffering. In the Caribbean, where HIV prevalence is second only to sub-Saharan Africa, all countries criminalize consensual sexual contact between men. It was stated that such institutionalized discrimination, combined with weak political leadership was contributing to the continued expansion of the epidemic.

12. Speakers stated that the ongoing revolution in communications technologies offered possibilities for accelerating community mobilization and social support and for educating young people about HIV. It was observed that 5 billion of the world's 7 billion people have mobile devices and are connected to the communications grid, suggesting possibilities for new strategies for intervention.

Panel II: a new generation of national partnerships: diversity in dialogue

13. The second panel examined strategies to maximize collaboration and partnership between diverse constituencies and sectors to strengthen the HIV response. It was agreed that collective efforts had been essential to the successes in the response to date and that partnership would be central to future success.

14. Speakers agreed that engaging civil society in effective partnerships required a respectful and reality-based recognition of the value of strong civil society engagement in national responses on all continents. For projects funded by the Global Fund to Fight AIDS, Tuberculosis and Malaria, the percentage of civil society projects receiving high performance rates is notably higher than the percentage for government-administered projects. Although many country coordinating mechanisms for the Global Fund reflect robust engagement of civil society, it was noted that participation of civil society remains inadequate in many country coordinating mechanisms and that countries with inadequate civil society engagement in country coordinating mechanisms should take steps to correct these weaknesses.

15. It was agreed that Governments, donors and other partners should recognize the humanity and rights of all individuals and communities affected by HIV, including those who might be considered "different" from prevailing social norms. In Nepal, it was noted that the decision by the Supreme Court to legalize homosexuality and recognize the rights of transgender people played an important role in reducing violence and abuse by security forces and strengthening the engagement of key populations in the national response. Universal decriminalization of sexual behaviours was urged as a prerequisite to meaningful partnerships. Countries also need to have meaningful and transparent measures in place to monitor their efforts to address HIV stigma and to promote effective responses for key populations at higher risk, including but not limited to sex workers, men who have sex with men and people who use drugs.

16. Too often, speakers observed, countries fail to allocate specific resources to programmes that address the needs of women and girls or to approaches that empower women and girls. In addition, too many national responses regard women

as vectors of transmission or passive victims of their circumstances, failing to address women's own health and support needs or to leverage women's considerable strengths and resilience. Speakers emphasized that the reliance of national responses on women's unpaid services is neither fair nor sustainable.

17. Although the importance of engaging young people is often noted, speakers advised that young people are seldom involved as full and meaningful partners in decision-making regarding HIV policies and programmes. Global Fund country coordinating mechanisms, for example, include little participation by young people. The failure to cultivate young people as future HIV leaders is short-sighted, undermining the long-term sustainability of national responses. In partnering with young people, national Governments and other stakeholders must recognize the extraordinary diversity of young people, avoid strategies that treat young people as a homogenous population, and ensure focused funding and programmatic attention to the needs of young people most at risk.

18. Speakers noted that the private sector needs to be actively engaged, and companies should be encouraged to demonstrate corporate social responsibility by contributing to HIV responses. A sustained and authentic business response extends well beyond the initial commitment, requiring companies to make long-term investments and build needed expertise and capacity.

Panel III: synergies among global movements: opportunities for shared action

19. The final thematic panel examined strategies to forge enhanced linkages and coalitions between HIV and other global movements. It was agreed that civil society, the private sector and Governments bring unique skills and capacities to national responses, and that the engagement of each is essential to future progress.

20. Speakers emphasized that decisive proof exists of the effectiveness of HIV prevention and treatment strategies, underscoring the urgent need to bring those to scale. Biomedical strategies to address HIV must be complemented by the engagement of diverse non-health sectors, with civil society playing a key role in linking these multiple approaches. To play its optimal role in supporting national responses, civil society requires access to information on epidemiology, national responses, and social and structural factors that affect HIV risk and vulnerability. Speakers also stressed the importance of building strong and durable national capacity for the response, including addressing the inadequacy of human resources. Urgent calls were made to strengthen efforts to protect children affected by HIV.

21. Effective responses to HIV depend on a strong and demonstrated commitment to social justice. Although a significant percentage of people living with HIV experience discrimination in employment and access to health care and other services, mechanisms to document and address instances of discrimination are generally inadequate.

22. The emergence of new prevention technologies, such as vaginal microbicides and pre-exposure prophylaxis, has the potential to strengthen national responses. Recent scientific advances underscore the critical importance of strong and continued support for HIV research, including, but not limited to, the development of safe and effective preventive vaccines. As new prevention and treatment tools

emerge, they must be effectively used and swiftly brought to scale in combination with already-existing tools, such as condoms.

Closing session

23. Maged El Syed Rabey, Programme Coordinator for the Friends of Life Organization in Egypt, reminded participants that decisions by Member States at the High-level Meeting would have permanent effects on the lives of people living with HIV and affected communities. Noting that young people in Egypt had changed the country's future, in part through the innovative use of communications technology, he called on young people to help change the course of the epidemic worldwide. Reiterating the continuing importance of universal access, he called for a response to HIV grounded in human rights. The Deputy Executive Director of UNAIDS seconded the call for a rights-based response, characterizing the HIV response as a movement for development, equity and social justice.

24. The President of the General Assembly closed the session by highlighting key themes from the day's proceedings. The President emphasized the importance of mobilizing sufficient resources for the response, citing the need for shared responsibility among donor countries, emerging economies, affected countries and the private sector. He called on Member States to ensure that no one is left behind in the AIDS response, urging that countries move from rhetoric to reality by aligning national laws with human rights principles and implement formal mechanisms to engage all communities affected by the epidemic.

25. The President emphasized the importance of cultivating and empowering a new generation of young leaders to fight stigma, influence public opinion, and affect social norms regarding sexual behaviour and human rights. He called on young people to be essential participants in policies and programmes that affect their lives.

26. Expressing deep appreciation to all speakers and participants in the civil society hearing, the President of the General Assembly adjourned the meeting and urged Member States to take the results of the day's deliberations into account in developing an outcome document for the High-level Meeting.

Principal recommendations

27. Principal recommendations made at the hearing include the following:

(a) Donors, national Governments and other partners should develop specific sources and mechanisms to supply community organizations with sufficient funding to support strong national responses and deliver essential services;

(b) The outcome document for the High-level Meeting should include clear funding targets for the response, including calling on all Member States to honour all prior financial commitments made to the Global Fund and to commit to sustainable, predictable and reliable funding to achieve universal access targets by 2015;

(c) Countries that are currently funding HIV below national capacity or offering HIV assistance at inadequate levels should be openly challenged to increase their contributions to the response. Emerging economies need not only self-finance

their own domestic responses, but should also transition to donors for the global response;

(d) Serious and expedited consideration should be given to innovative new financing strategies, including a surtax on financial transactions, to fund essential health and development programmes in resource-limited settings;

(e) Recognizing the goal of universal access to HIV prevention, treatment, care and support, a goal of 15 million people on antiretroviral therapy should be adopted for 2015;

(f) Countries should adopt and implement revised treatment guidelines that recommend earlier initiation of antiretroviral therapy, and strong and well-monitored linkage and referral systems should be in place to ensure that individuals receive the services they need, including, but not limited to, sexual and reproductive health services, services for hepatitis C and other co-morbidities, sexual education and programmes to eradicate gender-based violence;

(g) Countries urgently need to maximize the use of the flexibilities of the Agreement on Trade-Related Aspects of Intellectual Property Rights (the TRIPS Agreement) and other international intellectual property treaties and frameworks to obtain the most favourable prices for medicines and other essential commodities. Steps should be taken to ensure that bilateral trade agreements do not diminish the availability of generic drugs or the willingness of countries to use flexibilities that are available under international rules. The outcome document should reflect clear and unambiguous support for generic competition in order to lower drug prices. Innovative strategies, such as patent pools for HIV medicines and strategies that de-link the cost of research from the price of drugs, should be implemented in order to ensure further expansion of treatment access;

(h) Donors should take steps to minimize overhead costs for HIV assistance and prevent improper use of limited HIV financing;

(i) Resources must be strategically focused on the strategies, populations and geographic settings where they will have the greatest impact;

(j) Political leaders must demonstrate the courage to support rights-based, evidence-informed programming for key populations, including sex workers, men who have sex with men and people who inject drugs, and for other vulnerable populations, including migrant populations, prisoners and homeless people. The outcome document for the High-level Meeting should reinforce the vital need for Governments to recognize and implement evidence-based prevention programmes, especially for those focusing on key populations at higher risk. Donor restrictions on services for key populations (such as restrictions on services for sex workers, opioid substitution therapy, and needle and syringe programmes) should be eliminated, and countries should repeal punitive laws that block effective responses, including, but not limited to, laws or policies of criminalization;

(k) Countries should review and revise national legal and policy frameworks and ensure access to justice and legal services for all people affected by HIV;

(l) Member States should forge strong partnerships with civil society, taking into account the autonomy of civil society and basing partnership activities on principles of equality and mutual respect. In particular, Member States should

recognize the right of civil society to determine its own representatives in policymaking bodies;

(m) The risks and vulnerabilities of women and girls must be taken into account in national responses, including through budgeted activities with clear outcomes and accountability mechanisms;

(n) Young people must be involved in all levels of the response, including the planning, implementation and monitoring of policies and programmes that affect their lives. National responses should pay particular attention to the needs of young people who are most at risk, recognize young people's rights to sexual expression and autonomy, and ensure meaningful access to accurate, evidence-informed sexual education. Adequate and accessible funding streams must be created to support programming by and for young people. Intensified support is urgently needed to cultivate a new generation of HIV leaders;

(o) Donors, countries and other partners should take steps to ensure recognition and adequate compensation for all caregivers, who make critical contributions to national responses in all regions;

(p) Governments, organized labour and businesses should adopt the International Labour Organization's 2010 HIV recommendation, and employers and workers should forge strong working partnerships to implement successful, evidence-informed HIV workplace policies and programmes;

(q) Health workers should be recognized as a critical asset in the response, and their right to HIV prevention, treatment, care and support should be ensured. Member States should commit to reversing the loss of trained health professionals in low-income countries to higher-paid jobs in high-income countries. Countries should make more extensive use of appropriately compensated community health workers and take steps to integrate HIV in mainstream health and social support services;

(r) Social protection systems need to be strengthened and expanded to address the needs of children orphaned or made vulnerable by HIV. Urgent attention is also needed to close access gaps for paediatric HIV treatment and care, including scaling up early infant diagnosis. Linking the HIV response to broader social protection and child health programmes will exhibit the kind of synergistic response needed in future years to strengthen and sustain efforts to address the epidemic.

THE PRESIDENT
OF THE
GENERAL ASSEMBLY

20 October 2010

Excellency,

I have the honour to refer to General Assembly Decision 64/557 of 9 June 2010, in which the General Assembly decided to "undertake necessary consultations to determine during its sixty-fifth session, but no later than December 2010, the modalities and organizational arrangements for the comprehensive HIV/AIDS review in 2011".

In pursuance with the above-mentioned decision, I have the honour to inform you that I have appointed H.E. Mr. Gary Francis Quinlan, Permanent Representative of Australia, and H.E. Mr. Charles Thembani Ntwaagae, Permanent Representative of Botswana, to serve as Co-Facilitators and to lead these consultations.

I would like to thank Ambassador Quinlan and Ambassador Ntwaagae for accepting this responsibility and trust that you will extend your full cooperation and support to them.

Please accept, Excellency, the assurances of my highest consideration.

Joseph Deiss

All Permanent Representatives
and Permanent Observers to the United Nations
New York

THE PRESIDENT
OF THE
GENERAL ASSEMBLY

21 January 2011

Excellency,

On 20 December 2010 the General Assembly adopted resolution A/RES/65/180 (currently available as document A/65/L.49) entitled "Organization of the 2011 comprehensive review of the progress achieved in realizing the Declaration of Commitment on HIV/AIDS and the Political Declaration on HIV/AIDS". In this resolution the General Assembly requested "the President of the General Assembly to hold timely, open, transparent and inclusive consultations with all Member States, with a view to adopting a concise and action-oriented declaration, as an outcome of the high-level meeting to be agreed by Member States".

In accordance with the above resolution, I have the honour to inform you that I have reappointed H.E. Mr. Gary Francis Quinlan, Permanent Representative of Australia, and H.E. Mr. Charles Thembani Ntwaagae, Permanent Representative of Botswana, to serve as Co-Facilitators and to lead these consultations.

I would like to thank Ambassador Quinlan and Ambassador Ntwaagae for accepting this responsibility and trust that you will extend your full cooperation and support to them.

General Assembly resolution A/RES/65/180 also requested "the President of the General Assembly to organize, no later than in April 2011, an informal interactive civil society hearing". I have the honour to inform you that this will take place on 8 April 2011 and I look forward to your active participation and involvement.

Please accept, Excellency, the assurances of my highest consideration.

Joseph Deiss

All Permanent Representatives
and Permanent Observers to the United Nations
New York

THE PRESIDENT
OF THE
GENERAL ASSEMBLY

4 March 2011

Excellency,

On 20 December 2010, the General Assembly adopted resolution A/RES/65/180 entitled "Organization of the 2011 comprehensive review of the progress achieved in realizing the Declaration of Commitment on HIV/AIDS and the Political Declaration on HIV/AIDS", by which it decided to convene the High-level Meeting from 8 to 10 June 2011. The General Assembly also requested the President of the General Assembly to finalize the organizational arrangements for the High-level Meeting.

I am pleased to announce that arrangements for the meeting are already underway. The Secretary-General on 22 February 2011 issued an invitation to all Heads of State and Government calling for their participation in the High-level Meeting. An advanced unedited version of the Secretary-General's Report is expected to be available on 31 March 2011. In my letter of 21 January 2011, I announced that the informal interactive civil society hearing will take place on 8 April 2011.

As I have previously announced, I have established a Civil Society Task Force to assist me in organising the civil society hearing and with maximising civil society input to the High-level Meeting. The Civil Society Task Force met from 21 to 25 February 2011 and discussed the preparations for the informal interactive civil society hearing. The Task Force highlighted the strong desire of civil society for an interactive and meaningful discussion between civil society and Member States, which addresses progress and challenges in the HIV response at the community, national and global levels. I attach the draft agenda for the informal interactive civil society hearing for your attention.

Given the need to finalise urgently the arrangements for the informal interactive civil society hearing, I would be grateful if you could convey your inputs to Mr. Wasim Mir (mirw@un.org) in my Office on this issue by 14 March 2011.

In the coming weeks, pursuant to resolution 65/180, I shall, with support from the Joint United Nations Programme on HIV/AIDS and in consultation with Member States, finalise arrangements for the civil society hearing and the High-level Meeting, including the identification of a person openly living with HIV, an eminent person to speak at the opening plenary meeting and the identification of themes for the panel discussions.

I have requested the two facilitators, H.E. Mr. Gary Quinlan, Permanent Representative of Australia, and H.E. Mr. Charles Ntwaagae, Permanent Representative of Botswana, to consult on the preparations for this meeting. I wish to express my profound appreciation to them for their willingness to continue to undertake this important responsibility. The co-facilitators will be reaching out to Member States through regional groups. At the same time, delegations could also reach out to them bilaterally, should they have specific proposals on the way forward.

Please accept, Excellency, the assurances of my highest consideration.

Joseph Deiss

All Permanent Representatives and
Permanent Observers to the United Nations
New York

Civil Society Hearing for the High Level Meeting on HIV/AIDS: 8 April 2011

Proposed Draft Agenda

10.00 - 10.15	Opening Session Chaired by the PGA
10.15 - 11.45	Thematic Panel One - Enhancing Community-Level Access
11.45 - 13.15	Thematic Panel Two - A New Generation of National Partnerships
13.15 - 15.00	Lunch Break
15.00 - 16.45	Thematic Panel Three – Opportunities for Shared Action
16.45 - 17.00	Closing Session Chaired by the PGA

THE PRESIDENT
OF THE
GENERAL ASSEMBLY

29 March 2011

Excellency,

On 20 December 2010, the General Assembly adopted resolution 65/180 entitled "Organisation of the 2011 comprehensive review of the progress achieved in realizing the Declaration of Commitment on HIV/AIDS and the Political Declaration on HIV/AIDS".

In this resolution, the General Assembly requested "the President of the General Assembly to organize, no later than in April 2011, an informal interactive civil society hearing". In my letter of 21 January 2011, I announced that the informal interactive civil society hearing will take place on 8 April 2011.

I have the honour to transmit herewith an information note and draft programme for the informal interactive civil society hearing that has been finalized following consultations with Member States and civil society, and with the support of the Joint United Nations Programme on HIV/AIDS.

I would encourage all Member States to participate actively in the hearing at ambassadorial level, in line with the provisions of resolution 65/180. I very much look forward to an open dialogue and interaction between Member States and representatives of civil society organizations and the private sector on progress and challenges in the HIV/AIDS response, which will provide an important contribution to the upcoming high-level meeting.

Please accept, Excellency, the assurances of my highest consideration.

Joseph Deiss

All Permanent Representatives and
Permanent Observers to the United Nations
New York

Proposed arrangements for the informal interactive civil society hearing of the General Assembly on the 2011 comprehensive review of the progress achieved in realizing the Declaration of Commitment on HIV/AIDS and the Political Declaration on HIV/AIDS (8 April 2011, New York)

Information Note

I. Introduction

1. The General Assembly, by its resolution 65/180 of 20 December 2010, decided to convene a high-level meeting from 8 to 10 June 2011, to undertake a comprehensive review of the progress achieved in realizing the Declaration of Commitment on HIV/AIDS and the Political Declaration on HIV/AIDS.

2. By paragraph 9 of the resolution, the General Assembly requested the President of the General Assembly to organize, no later than in April 2011, an informal interactive civil society hearing with the active participation of people living with HIV and broader civil society, and attended by representatives of Member States, the Observer State and observers, non-governmental organizations in consultative status with the Economic and Social Council, invited civil society organizations and the private sector, as part of the preparatory process for the high-level meeting.

3. By paragraph 10 of the resolution, the General Assembly decided that the President of the General Assembly shall preside over the informal interactive hearing with representatives of non-governmental organizations, civil society organizations and the private sector, and requested the President to prepare a summary of the hearing, to be issued as a document of the Assembly prior to the high-level meeting.

4. The General Assembly by paragraph 11 of the resolution also encouraged Member States to actively participate in the hearing at ambassadorial level to facilitate interaction between Member States and representatives of non-governmental organizations, civil society organizations and the private sector.

5. The President of the General Assembly established a Civil Society Task Force to assist him in organising the informal interactive civil society hearing.

II. Information for participation

A. Date and venue

6. The informal interactive civil society hearing (thereafter "the Hearing") will be held on Friday, 8 April 2011 in the General Assembly Hall at United Nations Headquarters in New York.

B. Participation in the Hearing

Participation and Seating

7. In accordance with paragraph 9 of resolution 65/180, the Hearing will be open to representatives of Member States, the Observer State and observers, as well as non-governmental organizations in consultative status with the Economic and Social Council, invited civil society organizations and the private sector. The list of invited participants was determined by the President of the General Assembly in consultation with representatives of civil society and the private sector. Every attempt was made to ensure the list of invited participants was balanced in terms of geographic representation, gender and the different constituencies involved in the HIV/AIDS response.

8. To allow for an informal interactive exchange, all Member States, and some representatives of non-governmental organizations in consultative status with ECOSOC and invited civil society organizations and the private sector will have assigned seats on the floor of the General Assembly Hall. A proportion of the General Assembly Hall will be assigned to representatives of Member States who will be provided with name plates on arrival. This arrangement applies specifically to this informal interactive hearing and will in no way create a precedent for other meetings.

9. Remaining representatives of non-governmental organizations in consultative status with ECOSOC and invited civil society organizations and the private sector will be seated in the 3rd floor Gallery and 4th floor Balcony.

Programme and Speakers

10. The Hearing will consist of opening and closing sessions, and three sequential informal interactive panels. The President of the General Assembly will chair the opening and closing sessions. Opening remarks will be delivered by the President of the General Assembly, the Secretary-General, the UNAIDS Executive Director and a person living with HIV. Closing remarks will be delivered by the President of the General Assembly, the UNAIDS Executive Director and a person living with HIV (see Annex 1a).

11. The themes for the three panels will be:

- **Panel One - Enhancing Community-Level Access: Opportunities for Healing Social and Systemic Ills**
- **Panel Two - A New Generation of National Partnerships: Diversity in Dialogue**
- **Panel Three – Synergies among Global Movements: Opportunities for Shared Action**

12. Each of the three panels will be comprised of panellists representing civil society, representatives from Member States and an eminent person. Each panel will be overseen by a moderator. After brief presentations by the panellists, additional pre-selected civil

society representatives will be asked to make interventions from the floor (see Annex 1b). This will be followed by an interactive discussion with the floor. Concept notes for each of the three panels will be posted on the web site for the Hearing at www.unaids.org.

13. To provide for an informal interactive exchange, the moderator will call on other participants from Member States, civil society and the private sector to intervene in the order in which they ask for the floor, on the understanding that the exchange will balance the participation of those present.

C. Outcome of the Hearing

14. In accordance with paragraphs 9 and 10 of resolution 65/180, the Hearing will form part of the preparatory process for the high-level meeting, and the President of the General Assembly will prepare a summary of the hearing to be issued as a General Assembly document prior to the high-level meeting.

D. Media Arrangements

15. The Hearing, including the informal interactive panels, will be open to the media and will be broadcast in-house by United Nations Television, including through live Web-cast. A press conference will be organized after the Hearing. Media advisories will be distributed on-site and through United Nations Information Centres/services, and will be made available electronically on the web site for the Hearing, at www.unaids.org.

E. List of invited representatives of non-governmental organizations, civil society organizations and the private sector

16. The list of participants is posted on www.unaids.org.

Annex 1a

Informal interactive hearing with Civil Society for the high-level meeting on HIV/AIDS

Agenda

Friday, 8 April 2011, GA Hall

10.00 - 10.30	**Opening Session** Chaired by the President of the General Assembly Opening remarks by the President of the General Assembly, the Secretary-General, the UNAIDS Executive Director, and Ms. Jeanne Gapiya of 'Association Nationale de Soutien aux Séropositifs et aux Malades du SIDA (ANSS)'.
10.30 - 11.45	**Panel One**: Enhancing Community-Level Access: Opportunities for Healing Social and Systemic Ills
11.45 - 13.00	**Panel Two**: A New Generation of National Partnerships: Diversity in Dialogue
13.15 - 14.45	Lunch Break
15.00 - 16.45	**Panel Three**: Synergies among Global Movements: Opportunities for Shared Action
16.45 - 17.00	**Closing Session** Chaired by the President of the General Assembly Closing remarks by the President of the General Assembly, the UNAIDS Executive Director and Mr. Maged El Syed Rabey, Program Coordinator of 'Friends of Life Organization'.

Annex 1b

Informal interactive hearing with Civil Society for the high-level meeting on HIV/AIDS

Panellists and Speakers

Panel One: Enhancing Community-Level Access: Opportunities for Healing Social and Systemic Ills

Panellists

Civil Society:	**Mr Pardamean Napitu** (Indonesia), Indonesia Social Changes Organization (OPSI) **Mr Christopher Senyonjo** (Uganda), St. Paul's Foundation for International Reconciliation
Eminent Person:	**Mr Chris Hughes** (USA), Facebook
Member State:	**Ambassador Eric Goosby** (USA)

Speakers from the floor

Civil Society:	**Ms Nuraan Osman** (South Africa), Islamic Resource Foundation of South Africa **Ms Irina Maslova** (Russia), St Petersburg Charitable Public Organization for Support of Social Initiatives **Ms Rani Ravudi** (Fiji), Survival Advocacy Network Project

Panel Two: A New Generation of National Partnerships: Diversity in Dialogue

Panellists

Civil Society:	**Ms Natasha Leonchuk** (Ukraine), East Europe and Central Asia Union of PLWH **Dr Steave Nemande** (Cameroon), Alternatives-Cameroun
Eminent Person:	**Professor Michel Kazatchkine (France),** The Global Fund to Fight AIDS, Tuberculosis and Malaria
Member State:	**Hon. Sunil Pant** (Nepal), Nepal Constituent Assembly and Blue Diamond Society

Speakers from the floor

Civil Society:	**Mr Kenly Sikwese** (Zambia), Network of Zambian People Living with HIV/AIDS (NZP+) **Ms Maria Lorena Di Giano** (Argentina), Red Argentina de Mujeres Viviendo con VIH/SIDA **Ms Maxensia Nakibuuka Takirambule** (Uganda), Lungujja Community health caring organization (LUCOHECO)

Panel Three: Synergies among Global Movements: Opportunities for Shared Action

Panellists

Civil Society:	**Ms Manuella Donato** (Brazil), Global Youth Coalition on HIV/AIDS (GYCA) **Ms Kim Nichols** (USA), African Services Committee **Ms Veronica Cenac** (St Lucia), Caribbean Vulnerable Communities
Eminent Person:	**Professor Jeffrey Sachs** (USA), Columbia University
Member State:	**Ms Ana Isabel Nieto Gómez** (El Salvador), Ministerio de Salud Publica y Asistencia Social **Ambassador Anders Nordström** (Sweden), Department for Multilateral Development Cooperation Tbc, (Rwanda), Senior Government Representative

Speakers from the floor

Civil Society:	**Ms Nyaradzayi Gumbonzvanda** (Zimbabwe), World Young Women's Christian Association **Ms Janice Eastman** (Australia), Education International **Ms Joanne Lim-Pousard** (USA), Levi Strauss and Co.

THE PRESIDENT
OF THE
GENERAL ASSEMBLY

14 April 2011

Excellency,

On 20 December 2010, the General Assembly adopted resolution 65/180 entitled "Organisation of the 2011 comprehensive review of the progress achieved in realizing the Declaration of Commitment on HIV/AIDS and the Political Declaration on HIV/AIDS".

In this resolution the General Assembly requested 'the President of the General Assembly, with support from the Joint United Nations Programme on HIV/AIDS (UNAIDS) and in consultation with Member States, to finalize the organizational arrangements, including the identification of a person openly living with HIV and an eminent person actively engaged in the response to HIV/AIDS to speak at the opening plenary meeting, the identification of themes and finalization of the panel discussions for the High-Level Meeting.

Following consultations with Member States, held on my behalf by H.E. Mr. Gary Quinlan, Permanent Representative of Australia, and H.E. Mr. Charles Ntwaagae, Permanent Representative of Botswana, I have the honour to transmit herewith an information note on the organizational arrangements for the High-Level Meeting.

Please accept, Excellency, the assurances of my highest consideration.

Joseph Deiss

All Permanent Representatives and
Permanent Observers to the United Nations
New York

Organizational arrangements for the 2011 high-level meeting on the comprehensive review of the progress achieved in realizing the Declaration of Commitment on HIV/AIDS and the Political Declaration on HIV/AIDS (8-10 June 2011, New York)

Information Note 2

Introduction

1. The General Assembly, by its resolution 65/180 of 20 December 2010, decided to convene a high level meeting from 8 to 10 June 2011, to undertake a comprehensive review of the progress achieved in realizing the Declaration of Commitment on HIV/AIDS and the Political Declaration on HIV/AIDS.

2. By paragraph 16 of the resolution, it requested the President of the General Assembly, with support from the Joint United Nations Programme on HIV/AIDS (UNAIDS) and in consultation with Member States, to finalize the organizational arrangements, including the identification of a person openly living with HIV and an eminent person actively engaged in the response to HIV/AIDS to speak at the opening plenary meeting, the identification of themes and finalization of the panel discussions, and the arrangements for the informal interactive hearing with civil society. The arrangements for the informal interactive hearing with civil society were set out in the information note circulated to Member States by the President of the General Assembly on 29 March 2011.

Participation

3. Participation in the high-level meeting will be in accordance with paragraphs 2, 3, 4, 5, 6, 7, 8, 12 and 13 of resolution 65/180.

4. It is expected that the high-level meeting will be attended by several Heads of State and Government and will have a significant level of ministerial participation (Ministers of Health, Economy, Development, Finance, Foreign Affairs). In letters dated 22 February 2011, the Secretary-General extended an invitation to all Heads of State and Governments to participate at the high-level meeting.

5. In accordance with paragraph 14 of resolution 65/180, a list of civil society representatives that need accreditation to participate in the high-level meeting was drawn up by 31 March 2011 and was circulated to Member States, for consideration on a no-objection basis and for a final decision by the General Assembly.

6. Pursuant to paragraph 4 of resolution 65/180, Member States are encouraged to include in their national delegations to the high-level meeting parliamentarians and representatives of civil society.

Programme of the high-level meeting

7. Pursuant to paragraph 2(a) of resolution 65/180, the high-level meeting will comprise plenary meetings and five thematic panel discussions.

Plenary meetings

8. The plenary meetings are scheduled for the mornings and afternoons of 8, 9 and 10 June 2011.

9. Pursuant to paragraph 2(b) of resolution 65/180, the eminent person actively engaged in the response to HIV/AIDS to speak at the opening plenary will be H.E. Mr. Festus Gontebanye Mogae, former President of Botswana.

10. Pursuant to paragraph 2(b) of resolution 65/180, the name of the person openly living with HIV who will speak at the opening plenary meeting will be communicated in a subsequent note.

11. To enable maximum participation within the limited time available, statements in plenary should not exceed five minutes when speaking in the national capacity and eight minutes when speaking on behalf of a group. A list of speakers will be opened for inscription at the General Assembly Affairs Branch from 2 May 2011 (room IN-613A.tel. 1 (212) 963-5063; fax 1 (212) 963-3783; or e-mail: heddachem@un.org).

12. Representatives of civil society may attend the plenary meetings in the public gallery, within the limits of the space available.

Thematic Panel Discussions

13. The five panel discussions will be held as follows:

- Panel 1: Morning of Wednesday, 8 June 2011
- Panel 2: Afternoon of Wednesday, 8 June 2011
- Panel 3: Morning of Thursday, 9 June 2011
- Panel 4: Afternoon of Thursday, 9 June 2011
- Panel 5: Morning of Friday, 10 June 2011

14. The panel discussions will be open to Member States and observers, representatives of the United Nations system, as well as civil society representatives.

15. The panel discussions provide an opportunity to have in-depth discussions on the main findings and recommendations of the report of the Secretary-General (advanced unedited version circulated on 28 March 2011). They will focus on selected areas that require special attention to advance the HIV/AIDS response, and will help examine the progress made, promote sharing of best practices, identify challenges and gaps and sustainable ways to overcome them.

16. The themes for panel discussions will be:

Panel 1: Shared responsibility – a new global compact for HIV/AIDS

This panel will enable a discussion of priorities such as ensuring continued leadership and shared responsibility for the HIV/AIDS response, including a new generation of leadership, strengthening broad national ownership and engaging communities in order to foster local and sustainable solutions, securing long-term financing and increasing efficiency and ensuring mutual accountability of the future global response.

Panel 2: Prevention - What can be done to get to zero new infections?

This panel will enable a discussion of priorities such as the importance of accelerating targeted and effective prevention interventions, including eliminating stigma and discrimination, overcoming barriers to prevention for vulnerable groups, ensuring a comprehensive approach to prevention and treatment, and educating young people to lead the future HIV prevention efforts.

Panel 3: Innovation and new technologies

This panel will focus on opportunities for innovation and new technological developments in both treatment and prevention, smart investments in innovation, the more efficient use of resources and technologies and ensuring equity and access for these advances by those who need them most.

Panel 4: Women, girls and HIV

This panel will focus on the disproportionate burden of HIV/AIDS on women and girls and the need to ensure that their specific needs and vulnerabilities are adequately addressed. It could highlight the progress, challenges and opportunities in addressing the social determinants of women's and girl's vulnerability to HIV infection, as well as linkages between violence against women and girls and HIV.

Panel 5: Integrating the HIV/AIDS response with broader health and development agendas

This panel will focus on strategies for taking AIDS out of isolation and leveraging the response for broader health and development outcomes, strengthening health systems and enhancing links, coordination and cooperation with other areas of development at the local and global level. The panel will examine integration of HIV and TB services, as well as Sexual and Reproductive Health, and Maternal and Child Health services, with a focus on scaling up efforts to eliminate vertical transmission of HIV. The panel will also explore linkages with non-communicable diseases, food security/nutrition and education.

17. To promote interactive, free-flowing discussions, participants will be invited to make brief remarks not to exceed three minutes, raise questions and to respond to other speakers. Written statements are strongly discouraged.

18. To help focus on the specific issues relevant to each of the five panel discussions, background notes will be prepared for each panel discussion and circulated in due course.

19. The President of the General Assembly shall select, by a drawing of lots, the regional group whose member will chair each of the five panel discussions. Thereafter, each regional group, through its Chair, should communicate to the President of the General Assembly, no later than 6 May 2011, the representative of Government who will chair the panel discussion.

20. Each panel will be comprised of a Chair and three panellists with a thorough knowledge and expertise of the subject. They will include national, United Nations and civil society representatives. A moderator will be appointed by the President of the General Assembly to support the Chair of each panel, as appropriate.

21. The composition of the panels, including the chairs and the panellists, will be finalized by the President of the General Assembly, with due consideration given to geographic and gender balance, and communicated in a subsequent note.

22. Pursuant to paragraph 2 of resolution 65/180 the Chairs of the panel discussions will present summaries of the discussions to the closing plenary meeting.

Passes for Delegations

23. The United Nations Protocol and Liaison Service will authorize delegation passes, as well as VIP passes for Heads of State and Government and Cabinet Ministers. To facilitate the issuance of these passes, lists of delegations should be submitted to the United Nations Protocol and Liaison Service (room NL-2058; tel: 1 (212) 963-7171; fax: 1 (212) 963-1921).

Side-Events

24. A calendar of various events related to the high-level meeting from 8 to 10 June will be posted on the website of the President of the General Assembly.

THE PRESIDENT
OF THE
GENERAL ASSEMBLY

21 April 2011

Excellency,

Pursuant to my letter of 14 April 2011 to Member States transmitting the information note on the arrangements for the high-level meeting on HIV/AIDS scheduled for 8 to 10 June 2011, I invited the Chairpersons of the five regional groups for the month of April 2011 to my office today to witness the drawing of lots to select the regional group that will nominate a candidate to chair one of the five panel discussions at the high-level meeting. The results of the draw are as follows:

Panel 1: Shared responsibility – a new global compact for HIV/AIDS
Chair: Group of Latin American and Caribbean States

Panel 2: Prevention - What can be done to get to zero new infections?
Chair: Group of Western European and Other States

Panel 3: Innovation and new technologies
Chair: Group of Asian States

Panel 4: Women, girls and HIV
Chair: Group of Eastern European States

Panel 5: Integrating the HIV/AIDS response with broader health and development agendas
Chair: Group of African States

Each panel discussion will be chaired by a representative of a government, at the ministerial level or above. Regional group Chairpersons are requested to communicate the name of the panel Chair not later than 6 May 2011.

Please accept, Excellency, the assurances of my highest consideration.

Joseph Deiss

All Permanent Representatives and
Permanent Observers to the United Nations
New York

THE PRESIDENT
OF THE
GENERAL ASSEMBLY

09 May 2011

Excellency,

Pursuant to operative paragraph 9 of resolution A/RES/65/180 of 20 December 2010 entitled "Organization of the 2011 comprehensive review of the progress achieved in realizing the Declaration of Commitment on HIV/AIDS and the Political Declaration on HIV/AIDS", I convened, on 8 April 2011, an informal interactive civil society hearing as part of the preparatory process for the high-level meeting.

I am pleased to enclose herewith an advanced unedited summary of the informal interactive civil society hearing. In accordance with operative paragraph 10 of A/RES/65/180, this summary will be issued as a document of the Assembly prior to the high-level meeting.

Please accept, Excellency, the assurances of my highest consideration.

Joseph Deiss

All Permanent Representatives and
Permanent Observers to the United Nations
New York

Informal interactive hearings of the General Assembly with representatives of non-governmental organizations, civil society organizations and the private sector

1. An all-day civil society hearing was held on 8 April 2011 at the United Nations General Assembly. Presided over by H.E. Joseph Deiss, President of the General Assembly, the hearing aimed to inform preparations for the 2011 High Level Meeting on HIV/AIDS, including negotiations by Member States of an outcome document for the meeting.

2. Planned with the support of a Civil Society Task Force convened by the President of the General Assembly for purposes of preparing for the 2011 High Level Meeting, the hearing included an opening session, followed by three thematic sessions. Each moderated thematic session included brief comments by individual panellists, comments from designated civil society representatives, and a question-and-answer session between the moderator and the panel.[1]

3. More than 400 civil society representatives participated in the hearing, including more than 100 individuals who either participated as panellists or made statements from the floor. This report summarizes key outcomes of the day-long hearing, providing summaries of each session. The purpose of this summary is to provide Member States with a resource in their consultations on the outcome document for the High Level Meeting. (An agenda of the hearings, including moderators and participants for each session, is attached to this report.)

Opening session

4. Welcoming participants to the day-long hearing, the President of the General Assembly reminded attendees that five years had passed since the General Assembly embraced the ambitious goal of universal access to HIV prevention, treatment, care and support. The hearing was convened not to reach decisions but rather to promote sharing of knowledge and best practices.

5. United Nations Secretary-General Ban Ki-moon expressed gratitude and recognition for the leadership of civil society in the HIV response. The Secretary-General's report to the General Assembly for the High Level Meeting urges endorsement of new goals for the response, including reducing HIV transmission by half by 2015, providing treatment to at least 13 million people, eliminating vertical transmission, and sharply reducing the number of countries with punitive laws. The Secretary-General reminded participants of the global vision of a world with zero new infections, zero AIDS deaths, and zero discrimination.

6. Michel Sidibé, Executive Director of UNAIDS, advised that the HIV response was undergoing an important transformation, transcending a silo approach and linking more closely to other movements. Jeanne Gapiya-Niyonzima, founder of the Association Nationale de Soutien aux Séropositifs et aux Malades du SIDA in Burundi, emphasized the importance of continuing commitment in the HIV response, advising that there is "no room for complacency" and urging a strong working partnership between governments and civil society.

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[1]For background documents prepared for the hearing, see http://www.unaids.org/en/media/unaids/contentassets/documents/document/2011/20110408_CSH_Bgrd_en.pdf.

Panel I: Enhancing community level access: Opportunities for healing social and systemic ills

7. The first panel focused on strategies to leverage community resilience and insight to address underlying issues that contribute to the epidemic's continued expansion. Speakers highlighted the urgent need for robust and predictable funding for civil society organizations to ensure meaningful community engagement in the response. Participants warned against the imposition on communities of service models and HIV strategies that are externally formulated and implemented by non-community members.

8. A key theme of the first panel was the critical importance of sufficient financial resources to sustain an effective response and to advance progress towards universal access to HIV prevention, treatment, care and support. Speakers emphasized the need for clear funding targets for the response, for intensified advocacy to encourage countries to make sufficient financial contributions, and for maximized use of innovative financing mechanisms. The potential of innovative financing is evident in such instruments as the Global Fund and UNITAID, which make major contributions to financing national responses even though they are under-funded.

9. Speakers stressed that without additional increases in funding for HIV programmes and improved efficiency in the use of resources, it will be impossible to achieve universal access. Universal treatment access is not only critical to saving the lives of people living with HIV, but treatment also lowers viral load and thereby supports efforts to prevent new infections. Treatment is an essential element of "combination prevention," which involves the strategic use of biomedical, behavioural and social/structural strategies. It was noted that effective use of therapies to address HIV/TB co-infection would dramatically reduce HIV-related morbidity and mortality. Speakers also emphasized the importance of comprehensive care and support, including psychosocial support, financial assistance and access to palliative care. Optimal and creative use of flexibilities in intellectual property regulations was cited as an essential element of a successful strategy to achieve universal access. In particular, speakers warned that increasingly bilateral trade agreements are being used to undermine both the availability of generic drugs and the freedom of countries to maximize access to essential medicines.

10. The need to focus HIV resources in a strategic manner was highlighted, as well as the importance of protecting against misuse of limited financing. In Asia, it was observed that roughly 90% of prevention funding for young people is targeted at low-risk youth, with minimal financing for programmes focused on the young people at greatest risk of infection, such as sex workers, men who have sex with men, and people who use drugs.

11. Speakers emphasized the pernicious effects of persistent stigma and discrimination, combined with the failure of national leaders to acknowledge the existence of key populations at higher risk. It was noted that, throughout much of Eastern Europe and Central Asia, official resistance to evidence-informed harm reduction programmes continues to result in avoidable HIV infections and needless human suffering. In the Caribbean, where HIV prevalence is second only to sub-Saharan Africa, all countries criminalise consensual sexual contact between men. In the face of such examples of institutionalised discrimination, it was stated that weak political leadership is contributing to the continued expansion of the epidemic.

12. Speakers stated that the ongoing revolution in communications technologies offers possibilities for accelerating community mobilization and social support and for educating

young people about HIV. It was observed that 5 billion of the world's 7 billion people have mobile devices and are connected to the communications grid, suggesting new strategies for intervention.

Panel II: A new generation of national partnerships: Diversity in dialogue

13. The second panel examined strategies to maximize collaboration and partnership between diverse constituencies and sectors to strengthen the HIV response. It was agreed that collective efforts had been essential to successes to date in the response and that partnership will be central to future success.

14. Speakers agreed that engaging civil society in effective partnerships requires a respectful and reality-based recognition of the value of strong civil society engagement in national responses in all continents. For projects funded by the Global Fund to Fight AIDS, Tuberculosis and Malaria, the percentage of civil society projects receiving high performance rates is notably higher than the percentage for government-administered projects. Although many Country Coordinating Mechanisms (CCMs) for the Global Fund reflect robust engagement of civil society, it was noted that participation of civil society remains inadequate in many CCMs and that countries with inadequate civil society engagement in CCMs should take steps to correct these weaknesses.

15. It was agreed that governments, donors and other partners recognize the humanity and rights of all individuals and communities affected by HIV, including those who might be considered "different" from prevailing social norms. In Nepal, it was noted that the decision by the Supreme Court to legalize homosexuality and recognize the rights of transgender people played an important role in reducing violence and abuse by security forces and strengthening the engagement of key populations in the national response. Universal decriminalisation of sexual behaviours was urged as a prerequisite to meaningful partnerships. Countries also need to have meaningful and transparent measures in place to monitor their efforts to address HIV stigma and to promote effective responses for key populations at higher risk, including but not limited to sex workers, men who have sex with men, and people who use drugs.

16. Too often, speakers observed, countries fail to allocate specific resources to programmes that address the needs of women and girls or to approaches that empower women and girls. In addition, too many national responses regard women as vectors of transmission or passive victims of their circumstances, failing to address women's own health and support needs or to leverage women's considerable strengths and resilience. Speakers emphasized that the reliance of national responses on women's unpaid services is neither fair nor sustainable.

17. Although the importance of engaging young people is often noted, speakers advised that young people are seldom involved as full and meaningful partners in decision-making regarding HIV policies and programmes. Global Fund CCMs, for example, include little participation by young people. The failure to cultivate young people as future HIV leaders is short-sighted, undermining the long-term sustainability of national responses. In partnering with young people, national governments and other stakeholders must recognize the extraordinary diversity of young people, avoid strategies that treat young people as a homogenous population, and ensure focused funding and programmatic attention to the needs of young people most at risk.

18. Speakers noted that the private sector needs to be actively engaged, and companies should be encouraged to demonstrate corporate social responsibility by contributing to HIV responses.

A sustained and authentic business response extends well beyond the initial commitment, requiring companies to make long-term investments and build needed expertise and capacity.

Panel III: Synergies among global movements: Opportunities for shared action

19. The final thematic panel examined strategies to forge enhanced linkages and coalitions between HIV and other global movements. It was agreed that civil society, the private sector and governments bring unique skills and capacities to national responses, and that the engagement of each is essential to future progress.

20. Speakers emphasized that decisive proof exists of the effectiveness of HIV prevention and treatment strategies, underscoring the urgent need to bring these to scale. Biomedical strategies to address HIV must be complemented by engagement of diverse non-health sectors, with civil society playing a key role in linking these multiple approaches. To play its optimal role in supporting national responses, civil society requires access to information on epidemiology, national responses, and social and structural factors that affect HIV risk and vulnerability. Speakers also stressed the importance of building strong and durable national capacity for the response, including addressing the inadequacy of human resources. Urgent calls were made to strengthen efforts to protect children affected by HIV.

21. Effective responses to HIV depend on a strong and demonstrated commitment to social justice. Although a significant percentage of people living with HIV experience discrimination in employment and access to health care and other services, mechanisms to document and address instances of discrimination are generally inadequate.

22. The emergence of new prevention technologies, such as vaginal microbicides and pre-exposure prophylaxis, has the potential to strengthen national responses. Recent scientific advances underscore the critical importance of strong and continued support for HIV research, including but not limited to the development of safe and effective preventive vaccines. As new prevention and treatment tools emerge, they must be effectively used and swiftly brought to scale in combination with already-existing tools, such as condoms.

Closing session

23. Maged El Syed Rabey, programme coordinator for the Friends of Life Organisation in Egypt, reminded participants that decisions by Member States at the High Level Meeting will have permanent effects on the lives of people living with HIV and affected communities. Noting that young people in Egypt had changed the country's future, in part through innovative use of communications technology, he called on young people to help change the course of the epidemic worldwide. Reiterating the continuing importance of universal access, he called for a response to HIV grounded in human rights. Jan Beagle, deputy executive director of UNAIDS, seconded the call for a rights-based response, characterizing the HIV response as a movement for development, equity and social justice.

24. The President of the General Assembly closed the session by highlighting key themes from the day's proceedings. The President emphasized the importance of mobilizing sufficient resources for the response, citing the need for shared responsibility among donor countries, emerging economies, affected countries and the private sector. He called on Member States to ensure that "no one is left behind in the AIDS response," urging that countries "move from rhetoric to reality by aligning national laws with human rights principles" and implement formal mechanisms to engage all communities affected by the epidemic.

25. The President emphasized the importance of cultivating and empowering a new generation of young leaders to fight stigma, influence public opinion, and affect social norms regarding sexual behaviour and human rights. He called on young people to be essential participants in policies and programmes that affect their lives.

26. Expressing deep appreciation to all speakers and participants in the civil society hearing, the President of the General Assembly adjourned the meeting and urged Member States to take the results of the day's deliberations into account in developing an outcome document for the High Level Meeting.

Principal recommendations

Principal recommendations made at the hearing include the following:

a. Donors, national governments and other partners should develop specific sources and mechanisms to supply community organisations with sufficient funding to support strong national responses and deliver essential services.

b. The outcome document for the High Level Meeting should include clear funding targets for the response, including calling on all Member States to honor all prior financial commitments made to the Global Fund; as well as, commit to sustainable, predictable and reliable funding to achieve Universal Access Targets by 2015.

c. Countries that are currently funding HIV below national capacity or offering HIV assistance at inadequate levels should be openly challenged to increase their contributions to the response. Emerging economies need not only self-finance their own domestic responses but should also transition to donors for the global response.

d. Serious and expedited consideration should be given to innovative new financing strategies, including surtax on financial transactions to fund essential health and development programmes in resource-limited settings.

e. Recognizing the goal of universal access to HIV prevention, treatment, care and support, a goal of 15 million people on antiretroviral therapy should be adopted for 2015.

f. Countries should adopt and implement revised treatment guidelines that recommend earlier initiation of antiretroviral therapy, and strong and well-monitored linkage and referral systems should be in place to ensure that individuals receive the services they need, including but not limited to sexual and reproductive health services, services for hepatitis C and other co-morbidities, sexuality education, and programmes to eradicate gender-based violence.

g. Countries urgently need to maximize the use of flexibilities of the TRIPS accord and other international intellectual property treaties and frameworks to obtain the most favourable prices for medicines and other essential commodities. Steps should be taken to ensure that bilateral trade agreements do not diminish the availability of generic drugs or the willingness of countries to use flexibilities that are available under international rules. The outcome document should reflect clear and unambiguous support for generic competition in order to lower drug prices. Innovative strategies, such as HIV medicines

patent pools and strategies that de-link the cost of research from the price of drugs should be implemented in order to ensure further expansion of treatment access.

h. Donors should take steps to minimize overhead costs for HIV assistance and prevent improper use of limited HIV financing.

i. Resources must be strategically focused on the strategies, populations and geographic settings where they will have the greatest impact.

j. Political leaders must demonstrate the courage to support rights-based, evidence-informed programming for key populations, including sex workers, men who have sex with men, and people who inject drugs, and for other vulnerable populations, including migrant populations, prisoners, and homeless people. The outcome document for the High Level Meeting should reinforce the vital need for governments to recognise and implement evidence-based prevention programmes, especially for those focusing on key populations at higher risk. Donor restrictions on services for key populations (such as restrictions on services for sex workers, opioid substitution therapy, and needle and syringe programmes) should be eliminated, and countries should repeal punitive laws that block effective responses, including but not limited to laws or policies of criminalisation.

k. Countries should review and revise national legal and policy frameworks and ensure access to justice and legal services for all people affected by HIV.

l. Member States should forge strong partnerships with civil society, taking into account the autonomy of civil society and basing partnership activities on principles of equality and mutual respect. In particular, Member States should recognize the right of civil society to determine its own representatives in policy-making bodies.

m. The risks and vulnerabilities of women and girls must be taken into account in national responses, including through budgeted activities with clear outcomes and accountability mechanisms.

n. Young people must be involved in all levels of the response, including the planning, implementation and monitoring of policies and programmes that affect their lives. National responses should pay particular attention to the needs of most-at-risk young people, recognize young people's rights to sexual expression and autonomy, and ensure meaningful access to accurate, evidence-informed sexual education. Adequate and accessible funding streams must be created to support programming by and for young people. Intensified support is urgently needed to cultivate a new generation of HIV leaders.

o. Donors, countries and other partners should take steps to ensure recognition and adequate compensation for all caregivers, who make critical contributions to national responses in all regions.

p. Governments, organized labour, and businesses should adopt the International Labour Organisation's 2010 HIV Recommendation, and employers and workers should forge strong working partnerships to implement successful, evidence-informed HIV workplace policies and programmes.

q. Health workers should be recognised as a critical asset in the response, and their right to HIV prevention, treatment, care and support should be ensured. Member States should commit to reverse the loss of trained health professionals in low-income countries to higher-paid jobs in high-income countries. Countries should make more extensive use of appropriately compensated community health workers, and take steps to integrate HIV in mainstream health and social support services.

r. Social protection systems need to be strengthened and expanded to address the needs of children orphaned or made vulnerable by HIV. Urgent attention is also needed to close access gaps for paediatric HIV treatment and care, including scaling up early infant diagnosis. Linking the HIV response to broader social protection and child health programmes will exhibit the kind of synergistic response needed in future years to strengthen and sustain efforts to address the epidemic.

THE PRESIDENT
OF THE
GENERAL ASSEMBLY

31 May 2011

Excellency,

On 20 December 2010, the General Assembly adopted resolution 65/180 entitled "Organisation of the 2011 comprehensive review of the progress achieved in realizing the Declaration of Commitment on HIV/AIDS and the Political Declaration on HIV/AIDS."

In this resolution the General Assembly requested "the President of the General assembly, with support from the Joint United Nations Programme on HIV/AIDS (UNAIDS) and in consultation with Member States, to finalise the organizational arrangements".

In this regard, I have the honour to transmit herewith a detailed information note on the organizational arrangements for the High-Level Meeting.

Please accept, Excellency, the assurances of my highest consideration.

Joseph Deiss

All Permanent Representatives and
Permanent Observers to the
United Nations
New York

Organizational arrangements for the 2011 high-level meeting on the comprehensive review of the progress achieved in realizing the Declaration of Commitment on HIV/AIDS and the Political Declaration on HIV/AIDS (8-10 June 2011, New York)

Information Note (No. 3)

Introduction

1. The General Assembly, by its resolution 65/180 of 20 December 2010, decided to convene a high level meeting from 8 to 10 June 2011, to undertake a comprehensive review of the progress achieved in realizing the Declaration of Commitment on HIV/AIDS and the Political Declaration on HIV/AIDS.

2. By paragraph 16 of the resolution, it requested the President of the General Assembly, with support from the Joint United Nations Programme on HIV/AIDS (UNAIDS) and in consultation with Member States, to finalize the organizational arrangements, including the identification of a person openly living with HIV and an eminent person actively engaged in the response to HIV/AIDS to speak at the opening plenary meeting, the identification of themes and finalization of the panel discussions, and the arrangements for the informal interactive hearing with civil society. On 8 April 2011, the President of the General Assembly organized an informal interactive civil society hearing, the summary of which has been issued as a document of the Assembly (A/65/835).

Participation

3. Participation in the high-level meeting will be in accordance with paragraphs 2, 3, 4, 5, 6, 7, 8, 12 and 13 of General Assembly resolution 65/180.

4. The high-level meeting will be attended by a number of Heads of State and Government and will have a significant level of ministerial participation. In letters dated 22 February 2011, the Secretary-General extended an invitation to all Heads of State and Governments to participate in the high-level meeting.

5. By decision 65/547, the General Assembly approved the list of non-ECOSOC accredited civil society representatives that will participate in the high-level meeting, including the panel discussions. Pursuant to paragraph 4 of resolution 65/180, Member States are encouraged to include in their national delegations to the high-level meeting parliamentarians and representatives of civil society.

Programme of the high-level meeting

6. Pursuant to paragraph 2(a) of resolution 65/180, the high-level meeting will comprise plenary meetings and five thematic panel discussions. The programme of the high-level meeting is contained in Annex A.

Plenary meetings

7. By decision 65/548, the General Assembly decided that the opening plenary meeting will commence at 9 a.m. on Wednesday, 8 June. The plenary meetings are therefore scheduled from 9 a.m. - 1 p.m. and 3 - 6 p.m. on Wednesday, 8 June; 10 a.m. - 1 p.m. and 3 - 6 p.m. on Thursday, 9 June; and 10 a.m. - 1 p.m. and 3 - 6 p.m. on Friday, 10 June in the General Assembly Hall.

8. Pursuant to paragraph 2(b) of resolution 65/180, the eminent person actively engaged in the response to HIV/AIDS to speak at the plenary will be Dr. Mathilde Krim. Dr Krim is the founder of the American Foundation for AIDS Research (amfAR), the first private organization concerned with fostering and supporting AIDS research

9. Pursuant to paragraph 2(b) of resolution 65/180, the person openly living with HIV invited to speak at the opening plenary meeting is Ms. Tetyana Afanasiadi of Ukraine from the All Ukrainian Network of People Living with HIV/AIDS.

10. Pursuant to paragraph 13 of resolution 65/180, the representatives of non-governmental organizations in consultative status with the Economic and Social Council, civil society organizations and the private sector selected to be included in the list of speakers for the plenary meeting are: Dr. Brian Brink of South Africa from Anglo American plc; Ms. Esther Baucicault Stanislas of Haiti from the Fondation Esther Boucicault Stanislas; and Ms Silvia Petreti of the United Kingdom from the International Council of AIDS Service Organizations.

11. To enable maximum participation within the limited time available, statements in plenary should not exceed five minutes when speaking in the national capacity and eight minutes when speaking on behalf of a group. A list of speakers has been open for inscription at the General Assembly Affairs Branch since 2 May 2011 (room IN-613A. tel. 1 (212) 963-5063; fax 1 (212) 963-3783; or e-mail: heddachem@un.org).

12. Members of delegations may gain access to the General Assembly Building via the Delegates' Entrance. However, for the opening plenary on 8 June from 9 a.m. to 10 a.m. only holders of (a) a VIP pass or (b) a delegate's pass plus a colour-coded access card will be allowed to proceed to the main floor of the General Assembly Hall via the escalator. The remaining members of delegations wishing to follow the proceedings of the opening segment may proceed through the passage way leading to the General Assembly Lobby and take the elevator/stairs to the 3rd floor Gallery where access cards are not required. Seats will be available on a first come first served basis. For all other plenary sessions, no additional colour coded access card will be required.

13. Access to the main floor of the General Assembly Hall will be limited to six delegates per permanent mission/observer, two per intergovernmental organization and one per specialized agency. Access cards are not required for VIP pass holders.

Thematic Panel Discussions

14. The five thematic panel discussions will be held in Conference Room 2 as follows: Wednesday, 8 June from 10 a.m. - 1 p.m. and 3 - 6 p.m.; Thursday, 9 June from 10 a.m. - 1 p.m. and 3 – 6 p.m.; and Friday, 10 June from 10 a.m. - 1 p.m.

15. The thematic panel discussions provide an opportunity to have in-depth discussions on the main findings and recommendations of the report of the Secretary-General (A/65/797). To promote interactive, free-flowing discussions, participants will be I nvited to make brief remarks not to exceed five minutes, raise questions and to respond to other speakers. Written statements are strongly discouraged.

16. The thematic panel discussions will be open to Member States and observers and selected representatives of the United Nations system and civil society representatives. Due to limited availability of space, access to the panel discussions will be on the basis of colour-coded access cards, limited to two per Member State.

17. Each panel will be comprised of a Chair and three panellists with a thorough knowledge and expertise of the subject. They will include national, United Nations and civil society representatives. A moderator will be appointed by the President of the General Assembly to support the Chair of each panel, as appropriate.

18. Pursuant to paragraph 2 of resolution 65/180, the Chairs of the panel discussions will present summaries of the discussions to the closing plenary meeting.

19. The themes and composition of the panels are contained in Annex B and background papers, prepared by UNAIDS, for each panel discussion are contained in Annex C.

Overflow Room and Webcast

20. Conference Room 1 will serve as the "overflow room" to enable participants to follow proceedings of the opening plenary meeting and panel discussions.

21. The plenary meeting and the five panel discussions will be transmitted by live Web-cast.

Accreditation of Delegations

22. Accreditation of members of official delegations and members of the parties of Heads of State/Government, Vice-Presidents and Crown Prince/Princesses will be carried out by the Protocol and Liaison Service. Missions are kindly requested to submit their lists of delegations and requests for passes to the Protocol and Liaison Service at Room NL-2058 or by fax (212) 963-1921.

23. The colour-coded access cards for the opening plenary and panel discussions, referred to in paragraphs 12 and 16 above, will be available for pick up on Tuesday, 7 June 2011 starting from 10:00 am at the office of the Protocol and Liaison Service (NL-2058).

Security

24. Please note that the United Nations Headquarters premises will be closed to the public from 8-10 June. Regular guided tours will be suspended. The premises will reopen to the public on Saturday, 11 June, when guided tours will resume a regular schedule.

25. During the high-level meeting, the pedestrian gate at 45th Street and 1st Avenue will be closed for normal access. The 46th Street gate (south entrance) will be reserved for the use of high-level VIPs and delegates. Access to the Delegates' Entrance will be gained by entering the 46th Street gate and turning right at the top of the stairs, near the "Twisted Gun", in order to proceed to the Delegates Tent.

26. During the high-level meeting, the pedestrian gate at 47th Street and 1st Avenue will be accessible for VIPs and delegates.

27. On Wednesday, 08 June 2011, from 9 a.m. to 10 a.m., members of the delegations who are in possession of a VIP pass or a delegate's pass in addition to a colour-coded access card will be granted access to the main floor of the General Assembly Hall during the opening plenary. Please note that delegates who are not in possession of a colour-coded access card will be permitted to proceed to the third floor gallery and fourth floor balcony upon the presentation of their delegate's pass, until the capacity is filled. For the remaining plenary sessions, delegates wearing their United Nations grounds passes will have access to the General Assembly Hall without a colour-coded access card.

28. Escorted motorcades and vehicles of Permanent Representatives will be allowed to enter the United Nations premises at the 43rd Street and 1st Avenue vehicular entrance, drop off their passengers at the Delegate's Entrance, and then exit through the 45th Street and 1st Avenue gate. All escorted motorcades will be coordinated by the Host Country in conjunction with United Nations Security and Safety Service personnel.

29. All vehicles entering the garage are subject to search. Limitations on vehicle contents are to be observed so as to facilitate and expedite the security clearance.

30. Prior to the opening of the high-level meeting, the United Nations Pass and Identification Office will be open for the accreditation of delegates from Monday to Friday during the hours of 9.a.m. - 4 p.m.

Bilateral Meetings

31. Six temporary booths will be available on the 2nd and 3rd floor balconies of the General Assembly Building for bilateral meetings between member states. In order to provide equitable and efficient use of the facilities a reservation system has been instituted. Delegations are requested to submit requests electronically through eMeets (by accessing '*emeets.un.org*', then clicking onto *'bilats'* in the shortcuts section and logging in with the username and password of the Permanent Mission). Delegations unable to access eMeets may email their reservation to *Bilats-msu@un.org*. Delegations with inquiries may contact the Bilats Coordination Unit in the Department of General Assembly and Conference Management on tel: (212)963 2952.

Side-Events

32. A calendar of various events related to the high-level meeting from 8 to 10 June has been posted on the UNAIDS website. The side-events listed are subject to change. The organizers of these events are responsible for providing detailed information and updates, as appropriate.

Media arrangements

33. All members of the media accompanying Heads of State/Government or heads of delegation must submit a letter of assignment from their Bureau Chief or Editor-in-Chief, attached to an official letter from the Permanent Mission concerned, listing the names of the media representatives with their functional titles and affiliation, addressed to Isabelle Broyer, Chief, Media Accreditation and Liaison Unit, Department of Public Information, United Nations, fax: (212) 963 4642, email: malu@un.org.

34. Members of the media accompanying Heads of State/Government or heads of delegation must present themselves to the Media Accreditation Office (45th Street and 1st Avenue), where they will have their photographs taken and be issued a United Nations grounds pass upon presentation of national passports and valid photo identification.

35. All media representatives will be required to present a valid United Nations grounds pass to the United Nations security officers at the gate. The designated press entrance is at 42nd Street and 1st Avenue.

36. Media liaison desks will be available to assist the press on the third floor of the General Assembly building for securing access the booths in the General Assembly for TV crews and photographers and to obtain tickets to the fourth floor balcony for print press and outside of Conference Room 1 to allow media to be escorted to special

events in the North Lawn Building (NLB), as the press will not be allowed to move around the building without an escort. There will be stakeout areas for the press on the East Foyer on the second floor of the General Assembly building and outside of Conference Room 1 in the North Lawn Building.

List of Annexes and Attachments

37. The annexes and attachments to this information note are as follows:

Annex A: Updated programme of the high-level meeting
Annex B: Themes and composition of the thematic panel discussions
Annex C: Background notes for thematic panel discussions

Annex A

Programme of the high-level meeting

Wednesday, 8 June 2011		
9 – 10 a.m.	Opening plenary meeting *Statements by:* *H.E. Mr. Joseph Deiss, President of the General Assembly* *H.E. Mr. Ban Ki-moon, Secretary General* *Mr. Michel Sidibe, Executive Director, UNAIDS* *Ms. Tetyana Afanasiadi, GNP+* *Dr. Mathilde Krim, amfAR*	GA Hall*
10 a.m. – 1 p.m.	Plenary meeting	GA Hall
	Panel One *Shared responsibility – a new global compact for HIV/AIDS*	Conf Room 2*
3 – 6 p.m.	Plenary meeting	GA Hall
	Panel Two *Prevention - What can be done to get to zero new infections?*	Conf Room 2*
Thursday, 9 June 2011		
10 a.m. - 1 p.m.	Plenary meeting	GA Hall
	Panel Three *Innovation and new technologies*	Conf Room 2*
3 – 6 p.m.	Plenary meeting	GA Hall
	Panel Four *Women, girls and HIV*	Conf Room 2*
Friday, 10 June 2011		
10 a.m. - 1 p.m.	Plenary meeting	GA Hall
	Panel Five *Integrating the HIV/AIDS response with broader health and development agendas*	Conf Room 2*
3 – 6 p.m.	Closing plenary and adoption of the declaration.	GA Hall*

* Proceedings of these meetings will be transmitted to the overflow room (Conference Room 1).

Annex B

Thematic Panel Discussions

Panel discussions will be open to representatives of Member States and observers, representatives of the United Nations system as well as civil society representatives. Civil society representatives are invited to attend the panel discussions in the public gallery, within the limits of the space available.

The panelists have been selected based on their specific expertise and the recommendations of regional groups, UNAIDS and civil society. Effort was made to ensure equitable geographical representation.

The format for each panel will be as follows:

- The chair will give a brief introduction (maximum of seven minutes).
- Each panellist will speak for a maximum of seven minutes on the specific topic identified.
- Panellists' presentations will be followed by an interactive discussion, also involving civil society representatives, facilitated by a moderator. Interventions should not exceed five minutes.
- Participants are strongly discouraged from reading prepared statements in order to ensure that the discussions are interactive.

The themes and composition of the panel discussions are as follows:

Panel 1: Shared responsibility – a new global compact for HIV/AIDS

This panel will enable a discussion of priorities such as ensuring continued leadership and shared responsibility for the HIV/AIDS response, including a new generation of leadership, strengthening broad national ownership and engaging communities in order to foster local and sustainable solutions, securing long-term financing and increasing efficiency and ensuring mutual accountability of the future global response.

Date/Time: Wednesday, 8 June, 10 a.m. – 1 p.m. (Conference Room 2)

Chair: *H.E. Mr. Denzil L. Douglas, Prime Minister of St Kitts & Nevis*
National Representative: *Mr Søren Pind, Minister for Development Cooperation of Denmark*
Civil Society Representative: *Ms. Junéia Batista, Central Única dos Trabalhadores (Brazil)*

UN Representative: *Mr. Michel Sidibe, Executive Director of the Joint United Nations Programme on HIV/AIDS (UNAIDS)*
Moderator: *Mr. Riz Khan, Al Jazeera*

Panel 2: Prevention - What can be done to get to zero new infections?

This panel will enable a discussion of priorities such as the importance of accelerating targeted and effective prevention interventions, including eliminating stigma and discrimination, overcoming barriers to prevention for vulnerable groups, ensuring a comprehensive approach to prevention and treatment, and educating young people to lead the future HIV prevention efforts.

Date/Time: Wednesday, 8 June, 3 – 6 p.m. (Conference Room 2)

Chair: *H.E. Mrs. Marie-Josee Jacobs, Minister of Cooperation and Humanitarian Affairs of Luxembourg*
National representative: *Dr. Alexandre Padilha, Minister of Health of Brazil*
Civil Society Representative: *Mr. Jaevion Nelson, Jamaica Youth Advocacy Network (Jamaica)*
UN Representative: *Ms. Helen Clark, Administrator, United Nations Development Programme (UNDP)*
Moderator: *Ms. Kgomotso Matsunyane, South African Broadcasting Corporation*

Panel 3: **Innovation and new technologies**

This panel will focus on opportunities for innovation and new technological developments in both treatment and prevention, smart investments in innovation, the more efficient use of resources and technologies and ensuring equity and access for these advances by those who need them most.

Date/Time: Thursday, 9 June, 10 a.m. – 1 p.m. (Conference Room 2)

Chair: *H.E. Mr. Ratu Epeli Nailatakau, President of Fiji*
National Representative: *Dr. Jose Angel Cordova Villalobos, Minister of Health of Mexico*
Civil Society Representative: *Dr. Christoforos Mallouris, Global Network of People Living with HIV (Cyprus)*
UN Representative: *Dr. Margaret Chan, Director General, World Health Organisation (WHO)*
Moderator: *Mr. Andrew Jack, Financial Times*

Panel 4: Women, girls and HIV

This panel will focus on the disproportionate burden of HIV/AIDS on women and girls and the need to ensure that their specific needs and vulnerabilities are adequately addressed. It could highlight the progress, challenges and opportunities in addressing the social determinants of women's and girl's vulnerability to HIV infection, as well as linkages between violence against women and girls and HIV.

Date/Time: Thursday, 9 June, 3 – 6 p.m. (Conference Room 2)

Chair: *H.E. Mr. Hanno Pevkur, Minister of Social Affairs of Estonia*
National Representative: *Dr. Aaron Motsoaledi, Minister of Health of South Africa*
Civil Society Representative: *Ms. SiphiweHlophe, Swaziland Positive Living (Swaziland)*
UN Representative: *Mr. Babatunde Osotimehin, Executive Director, United Nations Population Fund (UNFPA)*
Moderator: *Ms. Stephanie Nolan, The Globe and Mail*

Panel 5: Integrating the HIV/AIDS response with broader health and development agendas

This panel will focus on strategies for taking AIDS out of isolation and leveraging the response for broader health and development outcomes, strengthening health systems and enhancing links, coordination and cooperation with other areas of development at the local and global level. The panel will examine integration of HIV and TB services, as well as Sexual and Reproductive Health, and Maternal and Child Health services, with a focus on scaling up efforts to eliminate vertical transmission of HIV. The panel will also explore linkages with non-communicable diseases, food security/nutrition and education. The President of the General Assembly has invited Ms. Françoise Barre Sinoussi, Director of the Pasteur Institute and Nobel Prize Winner to participate in Panel 5.

Date/Time: Friday, 10 June, 10 a.m. – 1 p.m. (Conference Room 2)

Chair: *H. E. Mr. Gervais Rufyikiri, Second Vice President of Burundi*
National Representative**:** *Mr. Daniel Bahr, Minister of Health of Germany*
Civil Society Representative: *Ms. Aditi Sharma, International Treatment Preparedness Coalition (India)*
UN Representative: *H.E. Mr. Jorge Sampaio, Secretary General's Special Representative to the Global Plan to Stop Tuberculosis*
Moderator: *Ms. Laurie Garrett, Council on Foreign Relations*

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Panel 1: Shared responsibility– a new global compact for HIV

This panel will enable a discussion of priorities, such as assuring continued leadership and shared responsibility for the AIDS response, including a new generation of leadership, strengthening broad national ownership and engaging communities to foster local and sustainable solutions, secure long-term financing and increase the efficiency of and ensure mutual accountability for the future global response.

OVERVIEW

The High Level Meeting provides a unique opportunity to build consensus on a new global compact for the AIDS response. The elements of the compact on shared responsibility to reach universal access on the journey towards zero new HIV infections, zero discrimination and zero AIDS-related deaths include:

- seizing opportunities for evolving global political and economic relationships while engaging a new generation and geography of leadership to foster country ownership of HIV responses;
- diversifying funding sources and innovative models of cooperation to accelerate efforts towards achieving the sustainability of national responses;
- mobilizing communities to foster local and sustainable solutions;
- increasing efficiency and effectiveness; and
- ensuring mutual accountability.

This compact can serve as a trailblazer in the pursuit of solidarity, equity and human dignity beyond the AIDS response—a pathfinder to a new deal of shared responsibility for health and development. ■

KEY ISSUES

The global AIDS response is at a pivotal juncture, reflecting new realities and new challenges, including the following.

Unprecedented, yet insufficient and fragile progress

Although the AIDS response has demonstrated remarkable success, the epidemic continues to outpace the response, with 2.6 million people newly infected every year, 1.8 million annual AIDS-related deaths and more than 9 million people living with HIV who are eligible for treatment but do not have access.

Waning political commitment and fragile country ownership

AIDS leadership across many low- and middle-income countries has emerged in recent years, but insufficient political will linked to limited country ownership of largely externally funded development agendas remain major impediments to relevant and sustainable national programmes.

An unsustainable trajectory of programme costs

The current costs of the response—of transactions, drugs and delivery—are unsustainable as HIV-related services are scaled up, especially given the game-changing evidence on how treatment can be used to prevent the transmission of HIV.

Declining available resources

The global economic downturn has evolved into a crisis of priorities. In stark contrast to the remarkable initial mobilization of resources—from US$ 300 million in 1996 to US$ 16 billion in 2009—available resources have not increased in recent years, largely as a result of a stagnation or declines in donor funding. This is particularly devastating, as international donors fund 93% of treatment in low-income countries. However, low- and middle-income counties are stepping up to the plate—domestic resources for HIV increased by some 10% last year—while middle-income countries, especially Brazil, the Russian Federation, India, China and South Africa (BRICS), are becoming important development partners. ■

WAY FORWARD

Shared responsibility to redouble political commitment and country ownership

Ending new infections and closing the treatment gap requires the same urgency, advocacy and political will that drove the first era of the response. A diverse range of countries have demonstrated ownership and shared responsibility, and this has led to impressive results for the HIV response and for wider health, human rights and development outcomes. However, high-income countries must not retreat from their obligation to support national responses—and their commitment must be revitalized.

Shared responsibility to bring people living with HIV and affected communities to the fore of the response

Governance of AIDS responses must reflect and promote the voice of people living with HIV and people at higher risk of HIV exposure, revitalize and link social movements, especially from the global South, youth and women's leadership, and strengthen community systems. Committing resources to community partnerships will enable more decentralized approaches to governance and will enhance communities' resilience to respond to their own needs and make health systems accountable accordingly.

Shared responsibility to meet investment needs for universal access

Universal access can be achieved by spending smartly and increasing annual investment to US$ 22 billion by 2015. These resources can be mobilized—by diversifying funding sources and balancing responsibilities.

Country ownership and sustainability will require increased and predictable long-term domestic and international funding. Scaling up innovative funding mechanisms, such as taxing financial transactions, will be key to closing the resource gap. High-income countries must meet pre-existing commitments—for universal access—fully aligning with partner country objectives and the engagement of all sectors. Recipient governments must be accountable for increasing domestic investment where possible and allocating resources where they are most needed.

Shared responsibility to overcome international and national obstacles to achieving universal access

Obstacles to competition, to production of generic antiretroviral medicine, to lower drug costs and to the use of TRIPS (Trade-Related Aspects of Intellectual Property Rights) flexibilities, such as trade policies and regulatory barriers, must be overcome, and the links between trade more generally and the achievement of the Millennium Development Goals must be addressed. Addressing punitive and discriminatory approaches that block access to HIV services also requires collaborative efforts. High-, middle and low-income countries alike have mutual obligations to achieve the minimum core content of the human right to the highest attainable standard of health and to protect the human rights of people living with, affected by and vulnerable to HIV.

Shared responsibility to reinforce new models of cooperation

Achieving universal access also requires new models of cooperation, including South–South and triangular cooperation and technology transfer. Many low- and middle-income countries have developed substantial experience in creating dynamic social, economic and scientific institutions. Solutions can now potentially be shared across the South. Innovative partnerships with the private sector to support service delivery and research, development and the introduction of and equitable access to technology and innovation must be expanded. ■

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Panel 2: Prevention–what can be done to get to zero new infections?

This panel will discuss priorities for: achieving HIV prevention goals; increasing the focus on effectiveness; eliminating HIV-related stigma, discrimination and legal barriers; including key populations at higher risk as allies in the response; empowering young people; and supporting HIV responses to get to zero new infections through effective prevention and treatment programmes that tackle underlying social and economic inequality.

A renaissance of HIV prevention action is needed, re-energizing combination prevention efforts and harnessing all the new prevention and communication technologies that have become available since the United Nations General Assembly Special Session on HIV/AIDS in 2001. A critical lesson has been that human rights and gender inequality must be addressed to achieve the goal of zero new HIV infections.

HIV prevention efforts must be based on clear, scientifically sound knowledge of the epidemic and response, priorities must be set in the specific local context, innovation must be harnessed and communities empowered to claim their right to health, including access to HIV prevention and treatment.

OVERVIEW

Despite strong progress in HIV prevention since the 2001 Special Session, the rate of people becoming newly infected still outpaces the capacity to extend treatment access and cope with the effects of HIV. The number of people newly infected with HIV has declined by nearly 20% in the past 10 years, yet every day 7000 people are infected with HIV.

Major advances are necessary that build on the successes of the 33 countries that have documented reducing the rate of people becoming newly infected with HIV by at least 25%. A strong and decisive downward trajectory in the epidemic is possible in all countries. This can only happen if human rights are realized in practice, the people most vulnerable to infection are supported, discrimination and punitive approaches are overcome and both new and existing prevention tools are used to maximize impact.

Rapid access is needed to the new and existing HIV prevention tools available, including male and female condoms, male circumcision, the elimination of vertical transmission and treatment for prevention—the use of antiretroviral therapy to block HIV transmission. Evidence shows that reaching key populations at higher risk—especially sex workers and their clients, men who have sex with men, people who inject drugs, prisoners and migrants—with effective HIV prevention and treatment is critical to bringing the HIV epidemic under control, but these populations are underserved by HIV programmes.

» The sexual transmission of HIV accounts for at least 80% of the people newly infected with HIV worldwide.

» A third of the people acquiring HIV infection are people younger than 25 years. Nevertheless, progress towards the 2001 goal of achieving comprehensive HIV knowledge among young people has been slow, and many programmes do not reach young people with the necessary HIV prevention services and commodities. Young people need to be reached at earlier ages before they may engage in high-risk sexual and drug use behaviour.

» In 2010, two thirds of countries reported the existence of laws or policies that pose an obstacle to access to HIV services by key populations at higher risk. Few countries have a budget for anti-stigma activities.

» Harm reduction and drug dependence treatment programmes reach fewer than 10% of the people who inject drugs worldwide. Coverage of outreach to sex workers and their clients and men who have sex with men is also low.

» HIV-related stigma and discrimination continue to prevent women from accessing HIV prevention services for themselves and accessing and adhering to programmes for preventing mother-to-child transmission. ■

KEY ISSUES

Leadership is key

Leaders across society must actively support the creation of enabling legal and social environments and effective investment to overcome the epidemic.

Overcoming systemic inequity in capacities and resources

The tools exist to know where new HIV infections are occurring and to select the right methods for an effective response, but systemic inequality, including global inequity in the availability of resources, means that these tools are not deployed.

Know your epidemic and response

Strategies for prevention must be tailored to the unique nature of the epidemic in each country or sub-national region. The effectiveness of the response must be assessed routinely and over years and fed back into decision-making.

Country ownership

Resources are currently spent on too many poorly defined interventions, often generated by outside donors, consultants or international groups, without any clear sense derived from data of which people are acquiring infection locally and how. Country ownership and meaningful participation by national actors from within and outside government, including affected communities, need to drive HIV prevention efforts.

Realizing rights in practice

Despite commitments by countries to eliminate punitive and discriminatory laws, policies and practices, many of these barriers have remained, and the protection of rights is not enforced or is inaccessible. People therefore fear getting tested for HIV or are unable to, fear disclosing their HIV status and fear accessing HIV prevention, treatment, care and support. Sex workers, men who have sex with men, transgender people and people who use drugs should be afforded the same rights to access nondiscriminatory services as any other members of the community. ■

WAY FORWARD

Successful responses must enhance the accountability of government and business leaders, nongovernmental groups and professionals in all sectors of the response.

Key HIV prevention tactics need to be delivered at the scale of the epidemic, including:

- programmes that create enabling environments and support nondiscrimination, informed consent and confidentiality and engage the justice, parliamentary and women's sectors;
- using the energy and innovation of young people to lead the future HIV prevention efforts;
- sexual and reproductive health and HIV programmes reaching young people, especially adolescent girls and in the context of drug use and sex work;
- comprehensive, culturally appropriate and age-specific HIV and sexuality education delivered by trained and supported educators within and outside schools;
- programming of male and female condoms;
- harm reduction services and drug dependence treatment;
- promoting male circumcision;
- improving access to antiretroviral therapy to prevent people from acquiring HIV infection, especially serodiscordant couples;
- focused behavioural and social change communication outreach to change norms around multiple and age-disparate partnerships; and
- practical human rights programmes, including 'know your rights and laws' campaigns, HIV-related legal services, measuring and reducing HIV-related stigma, programmes to prevent gender-based violence and training health care and law enforcement workers on nondiscrimination. ■

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Panel 3: Innovation and new technologies

This panel will focus on opportunities for innovation and new technological developments in both treatment and prevention, smart investment in innovation, the more efficient use of resources and technologies and ensuring equity and access for these advances to the people who need them most.

OVERVIEW

In the decade since the first United Nations General Assembly Special Session on HIV/AIDS in 2001, access to life-saving antiretroviral therapy for HIV infection increased by more than twenty-fold, to reach more than 6 million people by 2011. Central to this unprecedented achievement was a combination of the innovative technology that has led to highly effective antiretroviral medicines and improved access to that technology through the availability of low-cost, quality-assured drugs. Continued innovation of new technologies and equitable access will remain central challenges in effectively responding to HIV in the decades ahead. ■

KEY ISSUES

The urgent needs for innovation and access to new technologies such as drugs, diagnostics, vaccines, and microbicides fall roughly into three general categories: older existing technologies; newer and pipeline products; and missing technologies.

Older, existing technologies

» Many of the technologies widely used today are older, well-established products. For example, most widely used first-line antiretroviral medicines were invented or developed many years ago. People who develop resistance to their first- or second-line antiretroviral regimens need access to more recently developed antiretroviral medicines that are effective against drug-resistant HIV. However, the cost of many second- and third-line drugs can be many times higher than older, first-line drugs.

» Access to even older antiretroviral medicines and many other technologies still falls far short of the needs—for example, in 2010, about 9 million people living with HIV were eligible for treatment but did not have access to it.

Newer and pipeline products

» Newer, improved HIV technologies are much less widely used and/or available than older products for a variety of reasons, including costs associated with switching technologies such as retraining health workers and procurement and supply concerns.

» Newer medicines needed for treating certain opportunistic infections remain costly. Newer diagnostic and monitoring tools are often unavailable outside urban areas. For example, access is still extremely limited to viral load testing to monitor treatment and to tests that can reliably diagnose common coinfections such as drug-resistant tuberculosis (TB).

» New or pipeline products (products still in development) offer promising advantages over older technologies. For example, improved tests for monitoring treatment (CD4 and viral load) that can be used at the point of care have recently become available or are expected to be marketed within a few years. Newer antiretroviral medicines are also being developed that have reduced dosing frequency and therefore have fewer side effects, can be used by pregnant women and people receiving TB treatment and are more effective against strains of drug-resistant HIV.

Missing technologies

Many critical areas remain in which existing technologies are insufficient or needed technologies are missing altogether, including the following.

» Gaps in scientific or technological knowledge can hinder the development of effective products. An example is the ongoing search for an HIV vaccine.

» Research and development is often a long, risky process, and funding gaps at various stages can interrupt or cut short the pursuit of promising leads.

» Market incentives might be insufficient to attract investment into new product development.

» Important knowledge gaps persist if studies are not carried out regarding the safety, efficacy or usefulness of a technology in specific particular populations such as children, pregnant women and people receiving TB treatment. ■

WAY FORWARD

HIV treatment

The Global Strategy and Plan of Action on Public Health, Innovation and Intellectual Property calls for giving priority to transferring research and technology, among other actions. For HIV-related treatment issues, the following are needed.

» Ongoing research and development is needed for developing safer, more effective antiretroviral medicines that are easier to take.

» Additional fixed-dose combinations that combine two or more drugs into one pill are required.

» Injectable or oral drugs that could be administered weekly, monthly or every several months (similar to the injectable contraceptives used today) could dramatically simplify treatment, increase adherence and decrease demands on health systems.

» Innovation in service delivery and optimal use of existing medicines and other commodities and technologies.

» Improved medicines are needed for opportunistic infections – especially TB. The search for an HIV cure must continue.

HIV prevention

» Innovative, additional effective tools are urgently needed. For example, although effective protocols for preventing the transmission of HIV from mother to child already exist, access to these services remains low and transmission rates unacceptably high.

» Male and female condoms and a broader array of products to prevent sexual transmission of HIV are needed, especially such products as microbicides that women control. Prevention interventions such as male circumcision can also be beneficial under certain contexts.

» In addition, there have been some important research findings on using antiretroviral medicines as a prevention tool and on sing antiretroviral medicines for pre-exposure prophylaxis for high-risk HIV-negative individuals to reduce HIV transmission. Finally, research and development efforts towards achieving an effective vaccine should continue to be supported.

Policies for innovation and access to new technologies

» Push mechanisms seek to drive innovation by providing funding or other resources to actors in advance to conduct research or develop new products. Push mechanisms include government funding and public-private partnerships.

» Pull mechanisms seek to induce innovation by creating financial or other incentives to encourage research and development, with the potential rewards coming after the product is developed. This includes market approaches (patents or other forms of monopoly protection increase incentives by amplifying the size of the potential market for the innovator of a product) and advance market or purchase commitments.

» More systemic policies include patent pools such as the Medicines Patent Pool, which negotiates voluntary licences from patent holders and makes them available to product developers and generic drug manufacturers. ■

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Panel 4: Women, girls and HIV

This panel will focus on ensuring that the specific needs, rights and vulnerabilities of women and girls are adequately addressed. It will highlight opportunities to address the sociocultural, structural and economic determinants of HIV infection and links between HIV and sexual and reproductive health as well as violence.

The panel aims to identify game-changers that will help the HIV response to spark social transformation for women and girls to secure their human rights, protect themselves against HIV and act as agents of change. A game-changer is an innovative approach that is catalytic in nature, provoking results beyond the target group or original objectives and serving to trigger change in the HIV response.

OVERVIEW

HIV is as much a social problem as a medical one: 30 years into the epidemic, such factors as the lack of high-quality sexual and reproductive health services, violence, harmful cultural practices, lack of education and legal, political, social and economic disparities are driving the HIV epidemic among women and girls. These factors also contribute to poor sexual and reproductive health, including maternal, newborn and child health. This results in the following.

- Women 15–24 years old comprise 26% of all the people acquiring HIV infection.[i]
- The proportion of people living with HIV who are women is 51%. Women account for more than 60% in sub-Saharan Africa and 53% in the Caribbean.
- In concentrated epidemics, gender inequality places women at greater risk of acquiring infection through long-term intimate male partners. In Asia, the proportion of women living with HIV rose from 19% in 2000 to 35% in 2009.[ii]
- HIV-related causes contribute to at least 20% of maternal deaths.[iii] ■

KEY ISSUES

HIV and violence

- The risk of acquiring HIV infection among women who have experienced violence may be up to three times higher than among women who have not experienced violence.[iv]
- The national prevalence of forced first sex among adolescent girls younger than 15 years ranges between 11% and 45% globally.[v]
- In South Africa, a study indicates that nearly one in seven cases of people acquiring HIV infection could have been prevented if the women had not been subjected to physical or sexual abuse.[vi]

Gender inequality is a key determinant of the HIV epidemic

- In many societies, women face barriers in accessing HIV prevention, treatment, care and support services due to limited decision-making power, lack of control over financial resources, care responsibilities and restricted mobility.
- Lack of education is another major barrier, with two thirds of the world's 796 million illiterate adults being women.

» Denial of property and inheritance rights means that many women lose their homes, possessions, livelihoods and custody of their children if they lose their partner. This may force women to adopt survival strategies that increase their vulnerability to HIV.

» Early sex initiation and marriage are common worldwide, with many young girls dropping out of school and having sex with older men, thereby increasing their risk of HIV infection and reproductive and sexual ill health..

The HIV response is insufficiently meeting the needs and rights of women and girls

» UNGASS data indicate that only 46% of all countries allocate resources for the specific needs of women and girls in their national response to HIV, reflected in ineffective and inappropriate HIV programming. For example, in 2008, only 34% of pregnant women living with HIV were assessed for eligibility to receive antiretroviral therapy for their own health.

» Globally, less than 30% of young women have comprehensive knowledge on HIV prevention.

» Access to condoms for dual protection remains low: for example, only one female condom is available for every 36 women in sub-Saharan Africa. ■

WAY FORWARD

UNAIDS and partners call for effective action and integration of HIV into broader health and development platforms, to transform the HIV response. This panel will review game-changing interventions, including barriers for scaling up in the following areas: social change including gender norms and violence, health services, microfinance, education, sports and recreation, social media and information technology. Successful HIV responses – that involve many sectors and actors – need to tap into broader community action that supports and empowers young women and girls to turn the tide of the epidemic.

In social change, gender norms and violence, community-based participatory learning approaches are particular effective when HIV and violence prevention programming are paired with community mobilization and engaging men to challenge harmful gender norms. Health services interventions, when catalysing a multisectoral approach, address better the specific needs of women and girls, such as by linking HIV, eliminating violence, ensuring sexual and reproductive health and rights, addressing

stigma and bringing together health, social and legal services. Microfinance programmes for women have demonstrated success in empowering women to insist on safer sex. Further, innovative approaches to increasing access to education for girls have demonstrated success in terms of delayed marriage and childbearing, increased earning potential and reduced risk of HIV infection. Leveraging the sports and recreation sector to equip girls with life skills have contributed to empowering girls in their confidence in and care of their bodies, thus reducing vulnerability to HIV infection. Social media and information technology provide innovative ways for young people to acquire critical information on preventing HIV infection and violence and contribute to emergency responses.

The session will conclude by calling on political leaders and stakeholders to champion approaches focused on women and girls in policy and programming, utilizing innovative game-changers. ■

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i *UNAIDS report on the global aids epidemic 2010.*

ii *UNAIDS report on the global aids epidemic 2010.*

iii *UNAIDS report on the global aids epidemic 2010.*

iv Global Coalition on Women and AIDS and World Health Organization. *Intimate partner violence and HIV/AIDS.* Geneva, World Health Organization, 2004.

v *MPS notes: adolescent pregnancy.* Geneva, World Health Organization, 2008.

vi Jewkes RK et al. Intimate partner violence, relatuion power inequity, and incidence of HIV infection in young women in South Africa: a chort study. Lancet, 2010, 376:41–48.

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Panel 5: Integrating the AIDS response with broader health and development agendas

This panel will focus on strategies for taking AIDS out of isolation and leveraging the response for broader health and development outcomes, strengthening health systems and enhancing links, coordination and cooperation with other areas of development at the local and global levels to ensure healthier communities. The panel will highlight the lessons from integration of HIV and tuberculosis (TB) programmes and services and discuss links with sexual and reproductive health services and maternal, newborn and child health services, including efforts to eliminate new HIV infections among children and keeping their mothers alive. The panel will also explore broad links with noncommunicable diseases, food security, nutrition and education.

The panel aims to identify the key benefits and core elements for integrating HIV with other health and development agendas and to discuss how the strengths of the AIDS response can be leveraged to benefit these issues.

OVERVIEW

Thirty years into the HIV epidemic, AIDS has become an integral part of countries' health and development challenges. The effects of HIV infection intersect many other development challenges, such as food security, poverty, drug dependence, human rights and gender, and its effects on health and health systems are increasingly well understood. HIV has resulted in up to ten-fold increases in TB incidence in some African countries, is the leading cause of death among women of reproductive age worldwide and is associated with almost half of pregnancy-related and child deaths in some countries in southern Africa. HIV infection is also particularly frequent among people who inject drugs. Mitigating the effects of HIV is therefore essential to achieving Millennium Development Goal 6 and other development goals. Further, as access to antiretroviral therapy expands, the HIV response is evolving from a disease-specific emergency response to a challenge in managing chronic disease that needs to be addressed within the context of other chronic health conditions. Many countries with a high HIV prevalence are also facing burgeoning epidemics of other chronic infections, such as hepatitis B and C, and noncommunicable diseases, such as cardiovascular and chronic respiratory diseases and diabetes.

Within this broader context, recognition is increasing of the need for a more holistic approach to HIV and for integrating the delivery of HIV and other key health and development services within a client-centred continuum of care at the primary care level. An integrated approach can improve access, save costs and benefit clients and their families as well as programmes and development partners. ■

KEY ISSUES

HIV and health systems

» HIV responses rely on sustainable, functioning, nondiscriminatory health systems, including strong service delivery platforms, functioning procurement and supply systems and an effective health workforce. Blood safety and HIV and TB transmission in health care settings continue to be a challenge in many countries.

» Overall, the HIV response has strengthened health systems through a series of innovations including strengthened civil society participation, task-shifting and task-sharing, improved procurement management, quality assurance and donor coordination.

» Service delivery systems need to be further adapted to allow decentralized and high-quality chronic care close to the community

HIV, maternal, newborn and child health and sexual and reproductive health

» Eliminating new HIV infection among children—including continued HIV treatment and care for their mothers—is an integral element of the United Nations Secretary-General's Global Strategy for Women's and Children's Health.

» HIV prevention and treatment for women and children require a strong platform for delivering maternal, newborn and child health services as well as close links with efforts to ensure sexual and reproductive health and rights.

» HIV care and treatment for children needs to be integrated within existing childcare services to increase access to vaccination, nutrition assessment, education and supplements and complementary food, as needed, to improve broader health outcomes.

» Coordinating programmes better requires more integrated donor funding streams.

HIV and TB

» Modelling has shown 1 million TB deaths among people living with HIV could be averted by 2015 by implementing WHO-recommended integrated services.

» Of the registered TB patients in Africa, 53% were tested for HIV in 2009, and only one third of people living with HIV and TB started antiretroviral therapy.

» Efforts to prevent TB deaths among people living with HIV remain weak.

HIV and noncommunicable diseases

» As people living with HIV live longer, they develop more long-term complications, adverse drug effects and other chronic conditions.

» HIV programmes are often the first large-scale chronic disease management programmes in many low- and middle-income countries, offering effective models for lifelong continuity of care, adherence support and management that can be emulated, adapted and expanded.

» HIV (and TB and hepatitis) services should be linked with drug dependence, drug control and prison services to deliver integrated drug dependence services, including harm reduction interventions for people who inject drugs.

HIV and development

» The health sector response to HIV will falter if it is not implemented within the context of broader social and economic development and within an environment that respects human rights.

» Food and nutrition interventions combined with HIV and TB treatment can help improve the uptake and adherence of treatment and reduce mortality and morbidity while improving the quality of life of the affected individuals, households and communities.

» Lack of basic education can limit a person's ability to protect against HIV infection, reduce treatment literacy and ultimately affect family health and development.

WAY FORWARD

The time is right to explore the various ways in which the scaling up of HIV prevention, treatment, care and support may be leveraged to strengthen not only high-quality health services during specific periods of life such as pregnancy and childhood but responses to a range of other health conditions and development challenges. HIV responses cannot operate in isolation. Further scale-up requires functioning integrated health systems and communities that are empowered through access to essential rights and goods, including food, nutrition and basic education.

Key elements for effective integration of HIV responses with other programmes

- Coordination, including key stakeholders at the national, regional and district levels
- Joint policy guidelines and implementation tools
- Joint planning, budgeting resource mobilization, advocacy, communication and social mobilization
- Joint accountability with interlinked, standardized supervision, monitoring and evaluation
- Meaningful engagement of affected communities and key populations at higher risk
- A rights-based approach to ensure that the needs of the most vulnerable and marginalized people are met
- Empowering patients through counselling, treatment literacy, peer education, community engagement and adherence support
- Laboratory and drug procurement and supply chain management
- Decentralized diagnostics and strengthened laboratory capacity
- Comprehensive and integrated service delivery at the same place at the same time. ■