Joint United Nations Programme on HIV/AIDS
UNAIDS
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UNAIDS/PCB(9)/00
Conference Paper 2
25 May 2000

PROGRAMME COORDINATING BOARD

Ninth Meeting
Geneva, 25-26 May 2000

Global HIV/AIDS Strategy Framework

---WORK IN PROGRESS---

Preliminary Draft for Discussion – May 2000 version

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I. Background and Rationale for a New Strategic Approach

A. Overview and Status of the Epidemic

Since the HIV/AIDS epidemic began 20 years ago, over 50 million people have been infected with HIV. Countless others have become more impoverished as a consequence: children have lost their parents, families have lost their property; communities have lost teachers, health workers; business and government leaders; nations have lost their investments in decades of human resource development; and societies have lost untold potential contributions to their social, economic, political, cultural and spiritual life with the deaths of so many young people in their most productive years.

The first Global AIDS Strategy was prepared by the World Health Organisation in 1986. In 1991 the Global Strategy was greatly expanded, updated and refined in response to the epidemic's evolution and major scientific and policy advances. The updated Strategy was endorsed in January 1992 by the WHO Executive Board, and thereafter by the World Health Assembly and the Economic and Social Council of the United Nations.

A number of the basic principles and objectives of the first and updated Global Strategies remain valid today. However, the dramatically worsening scale and impact of the epidemic in some quarters, contrasting equally dramatic success in addressing it in others, necessitates a critical refocusing of our approach to this global catastrophe. Five reasons in particular necessitate this review.

1. The scale of the HIV/AIDS epidemic is now far greater than a decade ago, exceeding the worst-case projections made then.

The HIV/AIDS pandemic consists of multiple, concurrent epidemics. At the end of 1999, nearly 34 million people were living with HIV/AIDS, more than 23 million in Africa alone. In Asia, 6 million people are living with HIV/AIDS. There are 10 countries in Latin America and the Caribbean where prevalence in the adult population is above 1 percent. In Russia there were more new registered infections in 1999 than in all previous years combined.

At the end of the 1980s, HIV/AIDS was a well-established global pandemic. An estimated 10 million people had been infected since the beginning of the epidemic, and approximately 1.5 million had died. During the 1990s, over 40 million additional people were infected with HIV, and over 15 million deaths due to HIV/AIDS occurred worldwide.

2. The major impact of the pandemic is yet to come

HIV/AIDS has caused a development and potential security crisis in Sub-Saharan Africa and has made deep inroads into new regions in the past decade. While it is difficult to predict the future spread of the epidemic, the impact in terms of morbidity and mortality in the next decade is clear. Unless effective treatment and care is provided, an additional 15 million people currently infected with HIV will develop AIDS and die in the next five

years. In the hardest hit countries, over one-quarter of the medical staff who are needed to help those living with HIV/AIDS are themselves infected with the virus. In the agricultural sector, morbidity and mortality has already cut the production of many crops by more than 40% in households affected by AIDS. The impact on industry and the military may be greater, as rates of infections among men in the military and working in heavy industry is often much higher than in the general population.

The impact is clearly greatest in those countries that currently have the highest levels of prevalence. However, the impact of the epidemic will continue to worsen. According to the national estimates of South Africa, the number of people living with HIV/AIDS has increased by 50% in the last two years. While this rate of growth was the highest in the region, there are troubling signs of a worsening epidemic among many countries in central and western Africa. In the countries in the horn of Africa region, both political instability and insufficient efforts to stem the epidemic could lead to a rapid increase in prevalence.

3. Substantial experience and success has been accumulated.

The first two decades of the pandemic have been a period of unprecedented global learning and mobilization on AIDS. There is far better understanding of the policies and programmes needed to better respond to AIDS. Enough knowledge is available about the modes of transmission of HIV/AIDS to substantially slow the spread of the epidemic and mitigate its impact.

Prevention activities have clearly demonstrated that the spread of HIV can be reduced. There is strong evidence of decline of HIV incidence in populations with access to effective prevention, including communities in North America, Western Europe, Australia, East Africa and South-East Asia. A number of countries, including Senegal, Uganda and Thailand, have demonstrated the success of combining strong political leadership, multi-sectoral action which links across civil society and government, and openness in confronting human rights issues such as stigma and discrimination.

4. HIV/AIDS is increasingly being seen as a treatable disease.

Through advances in the treatment of opportunistic infections, and more recently as a consequence of the development of more effective antiviral therapies, HIV/AIDS is increasingly being seen as a treatable disease. As a consequence, prevention and care for HIV/AIDS are now viewed as inseparable and inter-dependent elements of the responses to HIV/AIDS, essential to mobilising community level responses to the epidemic. Recent and anticipated breakthroughs in strategies to improve access to powerful drugs at more affordable prices will likely further reduce the stigma associated with HIV/AIDS.

5. The capacity of partners to act has dramatically increased.

With the success of political mobilisation efforts in just the last few years, a much larger and more diverse set of actors have begun to focus on the response to the epidemic in the in severely affected and collaborating countries alike. As a consequence, there has been significant progress in assembling the essential political, development and technical

experience required to move the global response to scale. Increased financial resources are also being made available at an unprecedented rate through recent initiatives within affected countries, bilateral and multi-lateral development agencies, the private sector, and the foundation sector as well as through debt relief efforts. In addition, new communications capacities such as the Internet are enabling the partners in the response to interact and accelerate their learning at a pace unimagined even a decade ago.

B. Purpose of the Global Strategy Framework

The purpose of the Global Strategy Framework is explicitly to influence the development of the many thematic, sectoral, geographic and institutional strategies which, taken together, constitute a global strategy development process. The Framework itself should be regularly updated based on experience and feedback on its use and applicability within the global strategy process.

The Global Strategy Framework is intended to provide a common basis for the many independent actors in the response to the HIV/AIDS epidemic to formulate, re-evaluate and harmonise their own strategies. It is further intended to better enable the efforts of these multiple actors at local, national, and international level to be more synergistic with each other and more relevant to action at the community level.

The Global Strategy Framework seeks to advance a common understanding of the epidemic and a shared urgency to respond to the epidemic at scale. It also seeks to advance common goals, principles and a shared vision of a global response sufficient to contain this catastrophic epidemic.

II. Understanding the HIV/AIDS Epidemic

Our collective experience of the epidemic has evolved to the point where we can now state with confidence that it is technically, politically and financially feasible to forcefully harness the epidemic and dramatically reduce its spread and impact. It has been conclusively demonstrates that AIDS is caused by HIV infection.[1] Though the complexity of the HIV/AIDS epidemic has far exceeded all expectations, four basic “lessons” have emerged within our understanding of the epidemic:

first, that decreasing risk of infection slows the epidemic,

second, that decreasing vulnerability decreases the risk of infection,

third, that decreasing impact decreases vulnerability, and

fourth, and perhaps most importantly, an enabling environment is critical to supporting efforts to reduce risk, vulnerability and impact

1 Cite appropriate review

A. Decreasing Risk of Infection Slows the Epidemic

HIV infection is associated with specific risk taking behaviours and risk events. Risk reduction interventions have been the mainstay of ongoing HIV/AIDS prevention programmes. They include the provisions of information and the promotion of specific prevention methods, focussed on modulating risk taking behaviours and in decreasing the frequency of risk events.

Strategies addressing the epidemic should elaborate specific desired outcomes with respect to reducing the risk of HIV infection. These include, for example;

- the postponement of first sexual intercourse;
- the avoidance of traumatic sexual intercourse;
- the reduction of sexual partners;
- safer sexual practices such as regular condom use;
- the treatment of sexually transmitted diseases;
- the prevention of transmission from HIV infected mothers to their infants,
- the avoidance of unsafe injections, and
- the prevention of transmission through blood and blood products.

B. Decreasing Vulnerability Decreases Risk[2]

An individual's vulnerability to HIV is a measure of their ability to control their risk of infection. Personal factors, factors affecting access to relevant information and services, and societal factors may either mitigate or exacerbate individual vulnerability. For example, a young person with low self-esteem, who cannot access condoms, and is discriminated against with respect to education or employment on the basis of race, gender, sexual orientation or other characteristics, is more vulnerable than other young people with respect to HIV infection. In many settings, women -- and in particular young women -- are highly vulnerable to HIV infection.

The ultimate aim of vulnerability reduction strategies is to enable people to exert control over their own lives. A wide array of programme and policy interventions can hasten vulnerability reduction. At the level of the individual, **protective factors** contribute to decreasing vulnerability, regardless of socio-economic status, and particularly among youth. At the community level, **access to essential services** is enabling to individuals with respect to their ability to act on decisions to reduce their risk to HIV. At the societal level, **supportive social norms** decrease vulnerability by enhancing equity with respect to political, social and economic rights. In addition to enhancing risk reduction interventions, vulnerability reduction strategies also mitigate the negative consequence of HIV infection.

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2 UNAIDS BP Reference :Expanding the Global Response to HIV/AIDS through focused action: Reducing risk and vulnerability: definitions, rationale and pathways

The roots of vulnerability to HIV/AIDS are common to other social and health issues, including discrimination, violence, substance use, unwanted pregnancies and an array of communicable or non-communicable diseases. Consequently, vulnerability reduction strategies have positive benefits well beyond HIV/AIDS. Their design and execution should therefore be well integrated with other public health efforts.

Strategies addressing the epidemic should elaborate specific desired outcomes with respect to reducing vulnerability to HIV infection and AIDS.

Desired outcomes of vulnerability reduction strategies focused on youth and **promoting protective factors** would include, for example:

- positive relations with trusted adults,
- peer relations that model safer behaviors,
- participation in family, religious and community activities, and a
- positive orientation to health.

Desired outcomes of vulnerability reduction strategies promoting **access to essential services** would include, for example, increased access to:

- sexual health information and services;
- voluntary counseling and testing services,
- antenatal care that includes treatment to interrupt mother to child transmission;
- needle exchange programmes, and
- rehabilitation and legal services.

Desired outcomes of vulnerability reduction strategies promoting **supportive social norms** would include, for example, greater equity with respect to:

- educational, vocational training and employment opportunities;
- other rights and entitlements, and
- participation in community, religious and political activity.

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C. Decreasing Impact Decreases Vulnerability.

The AIDS epidemic impacts on the physical, mental, and social well being of individuals and on the social, economic and political life of their communities. The greater the impact of the epidemic on individuals, families and communities, the less they are able to respond effectively to it. Impact mitigation should be seen as an essential public good – a "mobilising strategy" to better enable those most affected by AIDS to become more effective partners in responding to the epidemic.

Prolonging the productive lives of individuals infected with HIV increases their ability to contribute to the well being of their families, helping to decrease the marginalization and pauperisation which can makes surviving family members more vulnerable to HIV. Similarly, increasing investments within affected communities in care, social support and general development efforts strengthens the capacity of those communities to respond to

the epidemic. Such actions contribute to creating an environment where the frank discussions required to address AIDS can take place. These, in turn, help to reduce the vulnerability of community members to HIV.

Strategies addressing the epide mic should elaborate specific desired outcomes with respect to reducing the impact of the epidemic.

Desired outcomes of strategies addressing **impact mitigation at the individual and family,** would include, for example:

- improved access to quality care and to basic social support services.
- increased direct support to lessening the catastrophic financial impact of HIV/AIDS on families
- earl and increased support to children – in particular with respect to their nutrition and continuing education,
- improved access to facilitated peer group and social support services, and
- improved access to legal services and protection.

Desired outcomes of strategies addressing **impact mitigation at community level,** might include, for example, increased community and external investments in:

- the capacity of community organisations for outreach to provide care and social support to affected families,
- general development efforts, including in essential infrastructure in the health, education and agriculture sectors, and
- vocatio nal training opportunities for young people who lack family support.

Desired outcomes of strategies addressing **impact mitigation at national level,** might include:

- policies which focus sound economic development programmes on communities most affected by the epidemic
- increased international technical and financial support to development efforts
- agreements to focus part of debt relief proceeds on high prevalence communities.
- Preferential access to essential commodities through price or trade policy concessions.

III. Creating an Enabling Environment

Efforts which address the HIV/AIDS epidemic at any level of action and within any sector or institution require some minimal conditions – an enabling environment – if they are to be successful. There are four major requirements to create an enabling environment for action:

First and foremost, reasoned public dialogue and supportive public policy is required to create an environment for action. In many settings, stigma and denial undermine efforts to openly address the behaviours that fuel the epidemic. In other settings, open hostility towards people affected by AIDS and individuals promoting AIDS awareness further reinforce stigma and inaction. In such circumstances, political, institutional and religious leadership has a special responsibility to break the silence and promote public dialogue and supportive public policy.

Second, priority setting, partnership facilitation and learning about the epidemic must receive adequate investment. Whether in a local community or a major international development agency, facilitation assistance is generally required to bring together the new partnerships needed to address the epidemic. Priority setting and systematic learning from experience requires a deliberate investment by leadership in periodic situation assessment, analysis, and performance monitoring against common objectives.

Third, essential human resource and institutional capacity strengthening requires attention and support. Frontline workers within relevant programmes and sectors will be more effective addressing AIDS in their work if they are assisted to address AIDS more effectively in their personal lives. Similarly, systems and institutions which are poorly designed or inadequately resourced or managed will require appropriate investment in essential infrastructure strengthening if they are to be expected to respond to the additional challenges posed by AIDS.

Fourth and finally, adequate financial resources and the systems needed to assure some degree of financial sustainability are required. Throughout, increased attention must be focussed on the reprioritisation of existing resources as well as to the mobilisation of the additional resources required to address AIDS.

Strategies addressing the epidemic should elaborate specific desired outcomes with respect to the creation of an enabling environment for action.

Desired outcomes of strategies addressing the **public dialogue and supportive public policy** elements of an enabling environment should include, for example:

- regular and supportive communication from political, institutional and religious leadership promoting understanding and action,
- more informed media coverage on the effects of the epidemic and on successful efforts to respond to it,
- strengthened advocacy capacities in community and civil society organisations responding to the epidemic, and

- public policies which address discrimination and stigma, and which promote access to the information and services required to address AIDS.

Desired outcomes of strategies addressing the **priority setting, partnership facilitation and learning** elements of an enabling environment should include:
- increased capacity for HIV/AIDS related planning, prioritisation, partnership, and networking within national governments and national and international organisations,
- increased capacity of local government and/or NGOs to facilitate local partnerships around common HIV/AIDS related priorities,
- improved information systems on which to base decisions on priorities and to measure performance, and
- explicit commitments to action by institutional and political leadership.

Desired outcomes of strategies addressing the **essential human resources and institutional capacity** elements of an enabling environment might include:
- increased sensitisation and support to front line government and institutional staff on HIV/AIDS issues that relate to their own families and personal lives,
- more intensive attention to workforce development in health, education, agriculture, uniformed services and other sectors which both impact on -- and have been severely affected by – the epidemic, and
- acceleration of essential infrastructure strengthening efforts in key sectors.

Desired outcomes of strategies addressing the **finance systems development** elements of an enabling environment might include:
- explicit plans for the reprioritisation of existing resource flows that reflect the new priority given to HIV/AIDS,
- explicit plans to adapt programme approaches and financing priorities within key sectors and programme areas related to HIV/AIDS such as schools, family planning and antenatal care, drug use rehabilitation,
- additional resources addressing HIV/AIDS from existing and new sources, and
- HIV/AIDS prominently included within debt relief plans of severely affected countries.

IV. Responding to the Epidemic

Containing and reversing the HIV/AIDS epidemic within this decade requires a response that is expanded, coordinated in support of community level action, intensified, prioritised, and executed at full-scale. Strategies addressing the epidemic must make a deliberate shift from the rhetoric of awareness and concern to than of commitment, action and accountability.

A. An Expanded Response is Required

An expanded response includes four major lines of action, simultaneously addressing the enabling environment, impact mitigation, vulnerability reduction and risk reduction.

While the optimal balance of these four elements will vary in different settings, all are required to effectively contain and control the HIV/AIDS pandemic.

It is feasible to mobilise an expanded response in communities significantly affected by the epidemic and in so doing influence other health and social issues that have a positive effect on people's overall physical, mental and social well being. This expanded response approach has its basis in practice rather than theory or aspiration.

- At community level, "target groups" are not so easily identified and accessed as they are in theory or in research studies. Consequently, **it is generally impractical to address risk reduction in isolation of vulnerability reduction.**

- Community acceptance of prevention interventions such as voluntary counseling and testing is as much related to the perceived benefits of care and than to the perceived benefits of prevention. Consequently, **it is generally impractical to address prevention in isolation of care.**

- Strategies that seek to address the epidemic in particularly hard-hit communities must take into consideration that existing services have been crushed under the burden of AIDS. AIDS specific services cannot be fielded without an infrastructure to carry them and resources systems to finance them Consequently, **it is generally impractical address access to services isolation of attention to essential human resource, infrastructure and finance systems.**

- The HIV/AIDS pandemic has deeply rooted societal causes. Interventions can sometimes be controversial and involve require adjustment of social norms. Consequently, **a human rights framework around which there is broad political consensus is indispensable in shaping strategies to address the enabling environment for action required within an expanded response to HIV/AIDS[3].**

B. A Multi-Level Response is Required

The outcome of the battle against AIDS is decided within the community. People within communities ultimately decide whether to adapt their sexual, economic and social behaviour to the advent of AIDS. Therefore, the response to AIDS must be viewed as primarily local, involving people where they live - their homes, neighborhoods and work places. A multi-level response is required to support effective community action, to coalesce local responses, and to mobilize a full-scale response.

Effective community-level responses to the epidemic must be both *empowering*, recognizing the rights of communities to make decisions, and *enabling*, assisting them to access the resources required to act on those decisions. The ultimate goal of pursuing community-level responses is to assist local communities to become skilled in dealing with AIDS, in particular so that they may be:

- properly informed about the epidemic,
- able to accurately assess the reality of HIV/AIDS within their community,

3 Cite BP Reference: Human rights and HIV/AIDS Framework

- able to analyse the determining factors of risk and of vulnerability effecting them personally, and their communities, and
- supported to act so as to address those determining factors.

Strategies addressing HIV/AIDS at the community level should include attention to the development of the local partnerships that may be required to improve the effectiveness of any particular set of local responses. Such partnerships, comprised of key social groups, government service providers, NGOs, community-based groups and religious organizations, help build the capacity of the various stakeholders. Facilitators who support the interaction between various partners also assist in building the self-confidence that progress can be achieved, and sharing that confidence and their experiences with other communities.

Strategies addressing HIV/AIDS supporting levels of action include those at the district, national and international levels. To enhance complementarity, actors at each level of the response should be able to visualize a successful response at community level, while formulating their own response with respect to the operational levels "above" and "below" them. Each successive level should focus on supporting the relative self-sufficiency of the previous level; the district level supporting the community, the national/provincial level supporting the district, and the international level supporting the national level response.

District level strategies should articulate how managers link local with national activities, identify and advocate key sector reforms required to sustain the response and negotiate them with national authorities. **National level strategies** should articulate how key actors, such as National AIDS Control Programmes, government ministries, NGOs, and the private sector can take local responses to scale by incorporating lessons learned into their strategic planning and reform processes. **Strategies at the international level** should articulate how research and development, technical collaboration, best practice development, and financial and resource mobilization efforts will national programmes to support and expand local responses.

C. An Immediate and Sustained Response is Required

Most countries and communities can immediately improve their responses to the epidemic by identifying, mobilising and reorienting existing resources to priority areas. Strategies addressing HIV/AIDS should include analysis of what is currently being spent and to what effect. They should also address what more could be achieved within current level of expenditures, based on shared best practices, and where additional resources can be utilised with most immediate effect.

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Strategies addressing HIV/AIDS must also take a long-term view and anticipate future needs when making current investments. For example, at the community level, investments in primary and secondary education for young people will pay dividends in decreased HIV incidence within a decade, particularly when those investments include life-skills approaches. At national level, social and economic policy adjustments can have substantial long-term effects on vulnerability reduction and consequently in HIV

transmission. Continued investments on more focussed research at the international level on new programme approaches and the development of new technologies, including vaccines, will be required to bolster programme effectiveness and reduce costs as the coverage of essential services increases over the course of the decade.

D. A Prioritised Response is Required

There is no single rationale to guide the prioritisation of investment of resources or the focus of programme efforts to address the epidemic. In general, strategies will need to strike a balance between areas of greatest need and those of greatest opportunity, recognising that these are not mutually exclusive criteria. Investments in creating an enabling environment for action are particularly crucial. The strengthening the information systems which monitor the epidemic and the response, thus facilitating further prioritisation of efforts, also requiring highest priority within programme strategies.

In general, whether at the international, national or community level, highest priority should be given to those geographic areas and populations with high prevalence or increasing incidence of HIV. In addition, experience has demonstrated that regardless of prevalence and incidence of HIV infection, "targeted intervention" strategies should always be given high priority. These prevention strategies focus on particular groups including; populations with high STD rates, intravenous drug users, commercial sex workers, and men in occupations that separate them from their communities, such as transit and migrant workers and the military. Interventions that are successful in reducing stigma and increasing visibility to the epidemic require special priority throughout, for example, strategies to prevent mother-to-child transmission of HIV.

Young people, young women in particular, constitute the general population group that should receive the highest priority for vulnerability reduction strategies. Impact mitigation strategies as well should give priority to communities with high prevalence, in particular to HIV infected individuals and children in families affected by HIV.

Sectors that can have the most significant impact in slowing the epidemic or mitigating its impact merit urgent attention, particularly if those same sectors are being heavily affected by the epidemic. The education, health, social welfare and agriculture sectors generally deserve the high priority in this regard.

E. A Full-Scale Response is Required

In virtually every community, country, institution and sector affected by or well placed to affect the AIDS epidemic, there is a profound and widening gap between what is possible and what is being done. Strategies addressing the epidemic must make a concerted qualitative and quantitative shift in orientation from pilot and demonstration projects to the full-scale response that is required to contain the epidemic. They need to begin with the desired impact and elaborate the necessary inputs rather than focusing more narrowly on how to make incremental improvements in the performance of current efforts. Strategies also need to be explicit in addressing what can be achieved with what levels of

expenditure and to include analysis of the social, economic, and political costs at various levels of not acting.

IV. Overarching Goals and Common Principles

A. Overarching Goal for Responding to the Epidemic

The overarching goal for the global response is to curtail the spread of HIV through effective local actions in order to reduce the impact of AIDS on human suffering and on the development of human and social capital.

Using existing tools and proven methods, it is technically feasible by 2010 to reduce the rate of new infections by:[4]

Global and Regional Estimates to be completed through Reference Group

B. Shared Vision

The partners to this Global Strategy Framework share a common vision that HIV transmission can be substantially reduced and eventually maintained at low levels using existing tools and proven methods

Further, that this vision can be achieved through intensified community organization and capacity building supported by a continuum of political processes, policy advocacy and programme development -- focussed primarily on young people[5] and vulnerable populations -- which address;

- individual, institutional and community behaviours or situations which contribute most significantly to HIV transmission and can be modified through targeted programmes,
- the most significant social and economic factors contributing to individual and community vulnerability to HIV infection,

4 Cite Secretariat Modeling Paper under development-Bernhard
5 Governments, with assistance fromUNAIDS and donors, should, by 2005, ensure that at least 90 per cent, and by 2010 at least 95 per cent, of young men and women aged 15 to 24 have access to the information, education and services necessary to develop the life skills required to reduce their vulnerability to HIV infection. Services should include access to preventive methods such as female and male condoms, voluntary testing, counselling and follow-up.

Governments should use, as a benchmark indicator, HIV infection rates in persons 15 to 24 years of age, with the goal of ensuring that by 2005 prevalence in this age group is reduced globally, and by 25 per cent in the most affected countries, and that by 2010 prevalence in this age group is reduced globally by 25 per cent.

- the coping capacities of individuals, families, communities and of the health and social sectors to address the impact of the HIV/AIDS epidemic.

Finally, that national governments in solidarity with the global community will mobilise the political, technical and financial resources required to realise this vision, as well as to increase and sustain the investments in research and development required to make available new methods and technologies, including an effective and affordable vaccine against HIV.

C. Common Principles

These efforts are based in the beliefs that:

- The respect, protection and fulfillment of human rights constitutes a core strategy which is indispensable to global efforts to address the epidemic.

- People living with AIDS must be actively engaged in setting the parameters for addressing HIV/AIDS around the world.

- National governments, in partnership with their civil societies, must provide the leadership to this global response and to assure that international efforts respond to country and community priorities.

- Access to essential life saving treatments and other scientific breakthroughs in prevention and care must be made available on an equitable basis.

D. Strategic Assumptions

The Framework is also based in two strategic assumptions drawn from accumulated experience in settings that are successfully addressing the epidemic, namely that:

- Increasing the visibility of the epidemic while simultaneously decreasing the stigma associated with HIV/AIDS is an essential prerequisite to a successful local or national response.

- The combined participation of many institutions and individuals working in close collaboration is critical for a successful response to the epidemic. These include in particular governments; the community of interested activists; people living with HIV/AIDS; NGOs; community-based organisations; religious and academic institutions; and the commercial sector.

V. Supporting Goals and Strategies

Supporting goals and strategies critical to the achievement of the overarching goal for the epidemic have been developed or are under development in key sectors, regions and thematic areas. Ten of those supporting goals together with key strategic objectives are summarised below. Additional supporting goals and strategic objectives, together with access information to additional strategic information, are provided in the Annex.

To be Further Developed Through Consultation Process

VI. Annex: Addressing Priority Issues through Inclusive Dialogue

Effective decision-making requires access to the most current and relevant strategic information drawn from focussed thematic, sectoral, geographic and institutional dialogues.

As an integral component parts of UNAIDS strategy development support, **Strategic Forums** have been established as a focus for the ongoing strategy development efforts of various stakeholder groups, including sectoral and thematic experts, collaborating institutions and organisations and governments

These Strategic Forums are intended to facilitate "learning" rather than "teaching". They are also intended to be inclusive of practitioners, policy makers and analysts and seek to add value to the flow of information to and among participants.

In addition to facilitating ongoing information exchange within a stakeholders group for the purpose of developing common supporting goals and objectives, each of the Strategic Forum are structured to provide public access to additional strategic information including:

- current summary information
- detailed background references
- Best Practice documentation
- training and programme materials
- information on the International Reference Group (membership, credentials, experience, and approach) which manages the content of the Forum
- direct links to related Forums, Collaborating Centres and Resource Centres.

Currently being constructed for WEB Access