Joint United Nations Programme on HIV/AIDS

UNAIDS

UNICEF • UNDP • UNFPA • UNDCP
UNESCO • WHO • WORLD BANK

UNAIDS/PCB(10)/00.3
2 November 2000

PROGRAMME COORDINATING BOARD

Third *ad hoc* thematic meeting
<u>Rio de Janeiro, 14-15 December 2000</u>

Provisional agenda item 3.

Framework for Global Leadership on HIV/AIDS

BACKGROUND

At its June 1999 meeting, the PCB encouraged the United Nations system to detail how it would articulate a Global HIV/AIDS Strategy, and support countries, bilateral donors, NGOs, the private sector and UN agencies to intensify their responses to HIV/AIDS. In May 2000, the PCB was presented with an update on the process for developing the Framework as well as with a working draft of the Framework (tabled as a conference room paper). The PCB welcomed the update and *"urged the Secretariat, Cosponsors and other partners to accelerate and intensify efforts to finalise the Framework for discussion at the Thematic PCB meeting in December 2000"*. At the Sixteenth Meeting of the Committee of Cosponsoring Organizations (CCO) on 4 October 2000, UNAIDS' Cosponsors reviewed a revised draft of the Framework -- **renamed the Framework for Global Leadership on HIV/AIDS** -- and plans for building consensus around the Leadership Commitments articulated within it.

PROCESS FOR BUILDING CONSENSUS AROUND THE GLOBAL FRAMEWORK

The Framework for Global Leadership is intended to influence the development of the many thematic, sectoral, geographic and institutional strategies which, taken together, constitute a global strategy process. As a consequence, the UNAIDS Secretariat has undertaken a wide consultation process around the Framework over the past six months. This has sought to both: (i) build consensus around the principles, vision and Leadership Commitments; and (ii) catalyse the development of supporting goals and strategies in respective sectors, regions, thematic areas, and institutions to operationalize the Framework.

The consultation process included events such as:

July 2000	International NGOs reviewed the working draft during a Consultation at the XIII International AIDS Conference, Durban.
Early September 2000	UNAIDS Secretariat identified and harmonized strategic priorities from regional and thematic strategy processes and incorporated them into a revised Framework with specific goals for policy makers

Mid September 2000	The UNAIDS Secretariat circulated the revised Framework to key actors in the strategic development process within the respective sectors, regions, thematic areas and institutions using e-mail and e-workspace technology. Comments were then shared, reviewed and reflected in a further draft.
1-3 October 2000	UNAIDS' Cosponsors held a Retreat to review the status of, and comments on the Framework for Global Leadership, and endorse the vision, principles and goals of the Strategic Framework for the Thematic PCB meeting in December 2000.
Mid October 2000	Cosponsors were invited to review and endorse a final draft of the Framework.
Early November 2000	The Framework for Global Leadership on HIV/AIDS was finalized for circulation to, and comments from PCB members.

NEXT STEPS

Over the past few months, mechanisms and technologies have been put in place to enable the many partners who are key stakeholders in the global strategy process to comment upon and help shape the Framework for Global Leadership on HIV/AIDS. This was designed to secure maximum "ownership" of the Framework internationally. Efforts are underway to sustain and expand strategic processes within respective regions, sectors, and thematic areas across diverse fields as well as institutions in different settings and at different levels - community, national and regional - once the Framework has been endorsed. For example:

- Inter-agency working groups will refine strategies for young people, school settings, orphans, care, gender, and the Administrative Committee on Coordination (ACC) Sub-Committee on Drug Control will finalize a strategy on HIV prevention among drug abusers.
- Regional strategy meetings for Latin America and the Caribbean, Eastern and Central Europe, South Asia and South East Asia will refine regional priorities for coordinated action in support of country efforts.
- Within the United Nations system, the Global Framework will guide the development of the United Nations System Strategic Plan for HIV/AIDS 2001-2005 and the institutional strategies for the various funds, programmes and specialized agencies which underpin it.
- The Framework should serve to inform and guide the development of additional goals and commitments in national and international fora including: the governing bodies of the Cosponsors, other UN system organizations, international NGOs and other partners, the ACC, the Economic and Social Council (ECOSOC) and the United Nations General Assembly Special Session on HIV/AIDS (UNGASS).

ACTION REQUIRED AT THIS MEETING

The PCB is invited to endorse the Framework, and provide further guidance to the UNAIDS Secretariat, Cosponsors and other partners to ensure widespread dissemination of the Framework and endorsement of the Leadership Commitments.

Joint United Nations Programme on HIV/AIDS

UNAIDS

UNICEF • UNDP • UNFPA • UNDCP
UNESCO • WHO • WORLD BANK

UNAIDS/PCB(10)/00.3
2 November 2000

Framework for Global Leadership on HIV/AIDS

I. Purpose and Rationale for an Updated Strategic Approach **4**

II. Lessons Learned **6**

III. Reinforcing Strategies of Risk, Vulnerability and Impact Reduction: The Expanded Response to the Epidemic **9**

- **A.** Decreasing Risk 10
- **B.** Decreasing Vulnerability 11
- **C.** Decreasing Impact 12
- **D.** Strategy Development in Different Settings 14

IV. Leadership Commitments and Core Actions **15**

V. The Way Forward **16**

I. Purpose and Rationale for an Updated Strategic Approach

1. The continuing world wide spread of HIV and the increasing global impact of the epidemic has made concerted action to halt the pandemic more important than ever before. At the 21st Special Session of the United Nations General Assembly in July 1999, Member States committed themselves to achieving major reductions in HIV infection rates among young people in the most affected countries by 2005, and globally by 2010[1] - the first specific global target against HIV.

2. The Framework for Global Leadership on HIV/AIDS provides a common strategic approach for achieving this global target. It encourages the many actors engaged in the response to intensify their efforts to achieve the existing global goal and to formulate the additional goals and milestones to bring the AIDS epidemic under control. The Framework calls for intensified leadership on the epidemic from within governments and civil society, including community, religious, political, media and private sector leaders.

3. The Global Framework seeks to advance a common understanding of the pandemic and its diversity, and a shared sense of urgency in responding at scale. It promotes a set of guiding principles and leadership commitments required to mobilise an expanded response to the epidemic. It is intended to provide a common basis for actors at global, national and community levels to formulate, re-evaluate and harmonise their own strategies. Its use will enable specific strategies concerning different themes, regions, sectors and institutions to be pursued in greater synergy with one another, to be better focussed on urgent priorities, and to be more relevant in supporting the actions required to contain the HIV/AIDS pandemic.

Aim

4. The overarching aim of the global strategy is to support communities and countries to reduce risk and vulnerability to infection, to save lives and alleviate human suffering, and to lessen the epidemic's overall impact on development.

Guiding Principles

5. The respect, protection and fulfillment of human rights constitutes the foundation of this Framework, the construction of which is guided by four fundamental principles:

- that gender inequalities fuelling the epidemic must be explicitly addressed,
- that prevention methods, life saving treatments and the results of scientific breakthroughs in prevention and care must be made broadly available on an equitable and affordable basis to all,

---

[1] *Governments, with assistance from UNAIDS 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, counseling 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.

- that people living with and affected by HIV/AIDS must be actively engaged and supported in their efforts to address the epidemic in communities around the world, and

- that national governments, working with civil society, must provide the leadership and means required to ensure that national and international efforts respond to country and community needs.

6. Applying these guiding principles to the most urgent priorities in responding to the epidemic gives rise to a set of essential Leadership Commitments for the future.

Leadership Commitments

1. To ensure an extraordinary response to the epidemic which includes the full engagement of top-level leaders to achieve measurable goals and targets

2. To reduce the stigma associated with HIV and AIDS and to protect human rights through personal and political advocacy and the promotion of policies that prevent discrimination and intolerance

3. To affirm and strengthen the capacity of communities to respond to the epidemic

4. To protect children and young people from the epidemic and its impact – especially orphans

5. To meet the HIV/AIDS-related needs of girls and young women and to minimise the circumstances that disadvantage women with respect to HIV/AIDS

6. To protect those at greatest risk of HIV/AIDS, including sex workers and their clients, injecting drug users and their sexual partners, men who have sex with men, refugees and internally displaced people, and persons separated from their families due to work or conflict

7. To ensure the provision of care and support to individuals, households and communities affected by HIV/AIDS

8. To promote the full participation of people living with and affected by HIV/AIDS in the response to the epidemic

9. To actively support the development of partnerships required to address the epidemic, in particular those required to improve access to essential information, services and commodities

10. To intensify efforts in socio-cultural, biomedical and operations research to accelerate access to prevention and care technologies, to improve our understanding of factors which influence the epidemic, and enhance actions to address it

11. To strengthen human resource and institutional capacities required to support service providers engaged in the response to the epidemic, in particular those in the education, health, judicial and social welfare sectors

12. To develop enabling policies, legislation and programmes which address individual and societal vulnerability to HIV/AIDS and mitigate its socio-economic impacts

II. Lessons Learned

7. 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.

8. 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 areas, contrasted with the equally significant success in addressing it in others, necessitates a critical refocusing of our approach.

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

9. By 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. In the decade of the 1990s, over 40 million additional people were infected with HIV and over 15 million deaths due to HIV/AIDS occurred worldwide.

10. The HIV/AIDS pandemic presently 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. There are 10 countries in Latin America and the Caribbean where prevalence in the adult population is above 1 percent. In parts of Eastern Europe there were more infections registered in 1999 than in all previous years combined, while in parts of southern Africa, the number of people living with HIV/AIDS has increased by 50% in the last two years. In Asia, 6 million people are living with HIV/AIDS and the number of new infections is increasing rapidly, particularly in South Asia.

11. In just 20 years, 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 millions of people in their most productive years.

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

12. HIV/AIDS has caused a development and potential security crisis in Sub-Saharan Africa and has made deep inroads into Asia, Latin America and the Caribbean, and Eastern Europe. While it is difficult to predict the future spread of the epidemic, the impact in terms of morbidity, mortality and impact on people's lives and communities in the next decade is clear. In the absence of access to effective treatment and care, an additional 15 million people currently infected with HIV will develop AIDS and die in the next five years.

13. In many countries, the AIDS epidemic has substantially undermined the institutional capacities relied upon by societies to protect their well being and support their development. 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. Experienced teachers are dying faster than new teachers can be trained, seriously affecting the supply and quality of education. The impact on industry and the military continues to grow rapidly, as the rate of infection among men in the armed forces and working in heavy industry is often much higher than in the general population.

14. The impact is clearly greatest in those countries that currently have the highest prevalence of HIV and the highest levels of poverty. The burden on women is particularly great, as they are often the primary care givers within families. Furthermore, the rapidly increasing number of children orphaned by AIDS poses major challenges for their well–being, as well as for the development of the communities in which they live. Increasingly, the epidemic is expanding into rural settings with significant implications for the agricultural sector. Morbidity and mortality have already cut the production of many crops by more than 40% in households affected by AIDS. Inevitably, the impact of the epidemic will continue to worsen in the coming decade.

3. Considerable success has been demonstrated in addressing the epidemic.

15. Collective experience with HIV/AIDS has evolved to the point where it is now possible to state with confidence that it is technically, politically and financially feasible to harness the epidemic and dramatically reduce its spread and impact. The first two decades of the pandemic have generated unprecedented learning and mobilization throughout the world. The causative agent of AIDS – HIV – has been definitively established and sufficient knowledge is available about its modes of transmission to substantially slow its spread.

16. The most important lesson learned from countries that have successfully responded to the epidemic has been the critical role of government and civil society leadership in increasing the visibility of the epidemic while decreasing the stigma associated with HIV/AIDS as an essential prerequisite for a successful response. There is now far greater understanding of the policies, programmes, and partnerships between government and civil society that are needed to better respond to HIV/AIDS across all social and economic sectors. In an increasing number of countries, these partnerships have begun to bring together the resources of governments and the international community with those of the community of interested activists: people living with HIV/AIDS, NGOs, community-based organisations, religious and academic institutions, and the commercial sector.

4. An even greater pandemic can be prevented in the future.

17. Vigorous measures taken now to reduce the rate of HIV infections will pay substantial dividends in years to come in countries with high and low prevalence alike. Prevention works. Large-scale prevention programmes in virtually all settings have clearly demonstrated that the spread of HIV can be reduced, especially among young people. In Asia, Australia, Europe, Latin America and the Caribbean, North America and Sub-Saharan Africa, there is strong evidence of the decline of HIV incidence in populations with access to effective prevention programmes. The documentation and dissemination of these successful experiences has enabled new partners in the response to more rapidly adopt similar approaches.

5. Capacity and commitment to act has increased.

18. With the success of political mobilisation efforts in recent years, a larger and more diverse set of actors has begun to focus on the response to the epidemic. As a consequence, there has been tangible progress in assembling the essential political, policy and technical experience required to mount a global response equal to the scale of the epidemic. Responses with strong political support across all planning and social sectors are increasing. Financial resources are now being made available at increased rates within affected countries, from bilateral and multi-lateral development agencies, the commercial and foundation sectors, and through debt relief efforts. In addition, new communications capacities such as the Internet are enabling partners to interact and access information at a pace unimagined even a decade ago. The prominence of HIV/AIDS in sub-regional, regional and global political forums – including the United Nations Security Council – has contributed enormously to strengthening political commitment and solidarity among national leaders. With improved communication and political solidarity, common ground is increasingly replacing the ideological divides that often hampered earlier efforts.

6. Care and support approaches for HIV/AIDS have become more effective.

19. The most effective responses to the epidemic have integrated education, prevention and care strategies as inter-dependent elements of the response. Efforts to mobilise community responses to the epidemic are substantially more effective when they address prevention, care and support needs, and when they involve multiple sectors.

20. Through advances in the management of opportunistic infections, and more recently through the development of more effective antiviral therapies, HIV/AIDS can increasingly be seen as a treatable disease. Recent and anticipated breakthroughs to extend access to life-saving drugs have the potential to improve people's health and assist them in sustaining their normal lives within their communities. These, in turn, can further reduce the stigma associated with HIV/AIDS.

7. Successful responses to the epidemic have their roots in communities.

21. It is at the community level that the outcome of the battle against AIDS will be decided. Containing and reversing the HIV/AIDS epidemic within this decade requires dramatically increased efforts in communities with increasing and/or high HIV prevalence, and in low prevalence areas where the pre-conditions exist for a rapid rise in HIV transmission. Local capacity for prevention, care and support efforts need to be recognised, affirmed and strengthened.

22. Effective community-centered efforts have generally been both *empowering*, strengthening the capacities of communities to make decisions, and *enabling*, assisting them to mobilize the resources required to act on those decisions. Community leaders who are properly informed are better able to assess the reality of HIV/AIDS within their particular community and to analyse the determining factors of risk and of vulnerability affecting them. On this basis, local actors can better address those determining factors and their consequences, and determine their priorities for action accordingly.

23. Successful strategies addressing HIV/AIDS at the community level require the development of partnerships to mobilise local responses. These partnerships, comprised of key social groups,

government service providers, NGOs, people living with HIV/AIDS, community-based groups and religious organizations, serve to strengthen the awareness and capacity of the various stakeholders.

8. People living with HIV/AIDS are central to the response.

24. At every level, from community to national to international, the benefits of a greater involvement of people living with HIV/AIDS have been shown. Stigma and discrimination towards people living with HIV/AIDS has been reduced by their visibility and involvement in local, national and international organizations. Their participation in policy, programme design and implementation has been instrumental in reorienting priorities, ensuring relevance and effectiveness, and increasing accountability. As advocates for intensified prevention efforts, people living with HIV/AIDS have been successful in bringing a human face and voice to the epidemic, challenging complacency and denial, strengthening the call for urgency in the response, and moving governments and their leaders to action.

III. Reinforcing Strategies of Risk, Vulnerability and Impact Reduction: The Expanded Response to the Epidemic

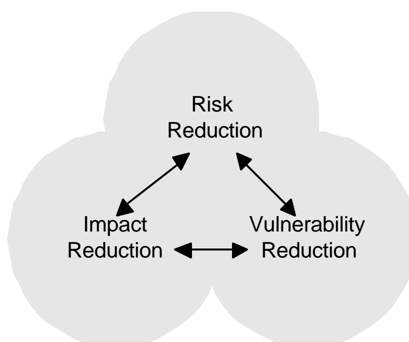
25. Though the complexity of addressing HIV/AIDS has far exceeded all expectations, we have come to recognise the inter-relationship of the basic dynamics of the epidemic:

decreasing the **risk** of infection slows the epidemic,

decreasing **vulnerability** decreases the risk of infection and the impact of the epidemic, and

decreasing the **impact** of the epidemic decreases vulnerability to HIV/AIDS.

26. **An "expanded response" to the epidemic is one that simultaneously acts on reducing risk, vulnerability and impact.** These reinforcing strategies enable programmes to address both <u>what</u> places individuals at risk and <u>why</u> they are at risk. An expanded response creates major synergies by placing prevention strategies alongside care and support strategies, while simultaneously promoting interventions designed to shift social norms, lessen stigma and increase political commitment to address these issues and the deep-seated gender and economic disparities which fuel the epidemic.



27. Impact, vulnerability and risk act on one another to shape the dynamics of the epidemic. Where the HIV/AIDS epidemic is worsening, a negative spiral is established as the impact of the epidemic causes increasing vulnerability - which increases the risk of HIV infection - which in turn increases impact. An expanded response enables this dynamic to be reversed: if the impact of the epidemic is lessened then vulnerability can be reduced and the risk of infection will fall, creating a positive spiral by further reducing impact.

28. By also addressing wider social problems such as poverty and gender inequality that help to drive the epidemic, an expanded response will influence general health and social issues multiplying its positive effect on people's overall well being.

A. Decreasing Risk of Infection Slows the Epidemic

29. HIV infection is associated with specific **risks**[2]**,** including**:**

- **behaviours** where there is a risk of HIV infection, most commonly unprotected sexual intercourse, and, in some parts of the world, the use of infected injecting equipment, and

- **situations** where there is a risk of HIV infection, such as needing a blood transfusion in a setting where blood safety precautions are not implemented, or being forced to have sex.

30. Risk reduction interventions have been the mainstay of HIV/AIDS prevention programmes to date. They include the provision of information, the development of relevant skills and the promotion of supportive values, attitudes and specific prevention methods, focussed on changing risk-taking behaviours and in decreasing the occurrence of risk situations. When risk reduction efforts are effective they slow the progress of the epidemic, thus reducing its impact and completing the positive spiral required to respond to the epidemic.

Desired outcomes with respect to
Reducing the Risk of HIV Infection.

These include:
- the postponement of first sexual intercourse;
- safer sexual practices such as consistent condom use;
- the reduction of the number of sexual partners;
- the prevention and treatment of sexually transmitted infections;
- the avoidance of traumatic sexual intercourse;
- the prevention of transmission from HIV infected mothers to their infants;
- the reduction in the harm associated with drug use, especially among young people;
- the avoidance of unsafe injections;
- the prevention of HIV transmission through blood and blood products;
- the prevention of HIV transmission within the health care setting.

---

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

B. Decreasing Vulnerability Decreases Risk of Infection and the Impact of the Epidemic

31. **An individual or a community's vulnerability to HIV is a measure of their ability to control the risk of infection**. Analysis of vulnerability enables a better understanding of the dynamics of the epidemic in particular settings. Factors that help to account for different patterns of infection include personal factors, factors affecting access to relevant information and services, and societal factors. In many settings, women -- and in particular young women -- are especially vulnerable to HIV infection. They may be less able than men to avoid non-consensual or coercive sexual relations. Cultural norms and stereotypes may also dictate that women should not appear to influence the sexual behavior of male partners.

32. Rural communities may be vulnerable because of lower levels of literacy and less access to information and services. When people become refugees or are internally displaced because of war, conflict or emergency situations, their vulnerability to HIV infection can increase as a consequence of disrupted social support mechanisms, inaccessibility of services, and increased non-consensual or coercive sexual relations.

33. To progress from analysis to action, vulnerability needs to be seen as a dynamic process in which individuals and communities can be supported to take greater control over their own lives and the risks they face, rather than simply as a static predisposition to higher rates of infection. Social exclusion is a major force that undermines this sense of control. Vulnerability reduction strategies, therefore, seek to replace exclusion with inclusion.

34. A wide array of programme and policy interventions can hasten vulnerability reduction. At the level of the individual, **protective factors,** as elaborated below, contribute to promoting social inclusion, particularly with respect to young people. At the community level, **access to essential services** enables individuals to act on decisions to reduce their risk to HIV and to access care and support. At the societal level, **supportive legal and social norms** decrease vulnerability by enhancing realisation of human rights - civil, political, economic, social and cultural. In addition to enhancing risk reduction interventions, social inclusion strategies also help to mitigate the negative consequences of HIV infection.

35. 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 and non-communicable diseases. Consequently, vulnerability reduction strategies have positive benefits on health and development well beyond HIV/AIDS. Their design and execution should therefore be well integrated with other development efforts.

Desired outcomes with respect to
Reducing Vulnerability to HIV Infection and AIDS.

Desired outcomes of vulnerability reduction strategies which, for example, focus on youth would promote **protective factors** including:

- positive relations with trusted adults;
- peer relations that model safer behaviors;
- participation in family, religious and community activities;
- positive orientation to education and health;
- the development of schools as more inclusive, protective and gender sensitive community-based organisations.

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

- sexual health information, education and services including information and access to male and female condoms;
- schools and other organised education programmes through secondary level;
- life-skills based HIV/AIDS education to develop the knowledge, attitudes and values needed to respond to the epidemic;
- voluntary counseling and testing services;
- antenatal care that includes treatment to reduce mother to child transmission;
- clean needles, syringes and drug abuse treatment in communities;
- rehabilitation and legal services.

Desired outcomes of vulnerability reduction strategies, which promote **supportive legal and social norms**, would include, for example:

- the reduction of gender and economic disparities that fuel the epidemic;
- greater equity in educational, vocational training and employment opportunities;
- increased participation in community, religious and political activity;
- the reduction of stigma associated with sex, sexuality, sex work and drug use;
- attention to policies or programmes which have the effect of perpetuating HIV within particular communities;
- the promotion and protection of human rights.

C. Decreasing Impact Decreases Vulnerability

36. The AIDS epidemic impacts on the physical, mental, and social well being of individuals and on the social, economic, cultural 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 strategies have as their objective supporting those who are most affected by the epidemic to become stronger partners in responding to it.

37. Prolonging the productive lives of individuals infected with HIV increases their ability to contribute to the well being of their families, also helping to decrease the discrimination and pauperization which can make surviving family members more vulnerable to HIV. Similarly, increasing investments in education, care, social support and general development efforts within affected communities strengthens their capacity to respond to the epidemic. Education, care and support strategies contribute to creating an environment where human rights are realised, stigma is

reduced, and the frank discussions required to address AIDS can take place. This more supportive and open environment, in turn, helps to reduce the vulnerability of community members to HIV infection.

Desired outcomes with respect to
Reducing the Impact of the Epidemic

Desired outcomes of strategies addressing **impact mitigation focussed on the individual and family level,** might include:

- increased direct support to reduce the catastrophic financial impact of HIV/AIDS on families;
- early and increased support to children, especially those orphaned by AIDS, focusing on their health, nutrition and education;
- increased vocational training opportunities for young people;
- improved access to quality care for people living with HIV including peer group support, voluntary counseling and testing, essential drugs and commodities, antiretrovirals, and to social support services;
- improved access to legal services, and human rights protection.

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

- the empowerment of communities to respond to issues at local level:
- the capacity of community organisations to carry out their activities, including outreach, and the provision of care and social support to affected families;
- the enhanced role of schools as centres for family and community service;
- assurance that community consultation occurs in HIV/AIDS policy and programme design and implementation;
- increased community and external investments in essential infrastructure in key sectors including health, education, social services and agriculture.

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

- guidance and policies which facilitate sound economic development programmes in communities most affected by the epidemic;
- strengthened national AIDS programmes and improved co-ordination of HIV/AIDS policy and programme responsibilities across all sectors of government;
- appropriate allocation of national resources to cover prevention, care and impact reduction activities matched with increased international financial and technical support;
- agreements to focus part of debt relief proceeds on high prevalence communities and impact reduction activities;
- preferential access to essential commodities through price or trade concessions.

D. Strategy Development in Different Settings

38. National strategic planning processes have stimulated central and local governments, NGOs, communities, and international partners in many countries to define strategies that are tailored to the different contexts within which HIV/AIDS evolves. Regional and sub-regional strategies have further complemented and added value to national responses. Most regions, countries and communities can improve their success in addressing the epidemic by applying new or existing resources to an expanded response, which simultaneously addresses vulnerability, risk and impact reduction. However, as the global pandemic is composed of multiple epidemics, each with their own particular dynamic, the optimal balance of these three strategies will vary in different settings. Settings with low but increasing incidence and those with high prevalence of HIV both require urgent priority. Strategy development within each setting will need to reflect its particular opportunities and constraints.

39. **In low endemic settings**, populations with the highest risks for infection can include populations with high STD rates, sex workers and their clients, injecting drug users and their sexual partners, men who have sex with men, and men and women in occupations that separate them from their communities, such as transit and migrant workers and the military. Strategies addressing the needs of these populations should include vulnerability, risk and impact reduction elements. While these population should receive priority, increasing political support for HIV/AIDS efforts, reducing stigma, and maintaining awareness among the general public must also be addressed. These essential elements for programme sustainability can present major challenges in low endemic settings requiring ongoing investments in advocacy and public information strategies. In communities with relatively few people infected by HIV/AIDS, care and support strategies require less financial investments, but nevertheless merit high priority from policymakers. In such settings, these strategies can be of substantial value in creating incentives for early detection and reducing the stigma of HIV infection, thus reducing vulnerability and reinforcing prevention efforts.

40. **In high endemic settings**, strategies focussed on particular populations with higher risks for infection continue to be relevant, but are of more limited value. In addressing the dynamics of a generalised epidemic, strategies to reduce impact require significantly more attention. Communities with highest HIV prevalence, and within them, individuals and families affected by HIV, demand particular priority. In especially hard-hit communities, strategies must take into consideration that existing services have been crushed under the burden of AIDS. The sectors most directly involved in slowing the spread or mitigating the impact of HIV/AIDS, such as the education, health, social welfare, and judicial sectors, require urgent investments to reinforce their human resources and institutional capacities, and support their frontline workers.

41. **In both low and high endemic settings**, reducing the vulnerability of young people to HIV infection constitutes the principle defense against the epidemics of the future. While vulnerability reduction strategies necessarily take a long-term view of the epidemic, they nevertheless require near-term investments to achieve their outcomes, such as increasing primary school enrollments and extending schooling for adolescents.

42. **In virtually every community, institution, sector, country and region affected by AIDS**, there is a profound and widening gap between what is needed to contain the epidemic and what is being done. If this gap is to be closed and the epidemic is to be contained, there must be a concerted shift from pilot and demonstration projects to a full-scale expanded response. In all of these settings,

leadership in responding to the epidemic is the most essential ingredient for success. Leaders within governments and civil society, including community, religious, media and private sector leaders, have an opportunity and responsibility to assure this success by creating an environment of:

- **understanding**, based on reasoned public dialogue and supportive public policy;
- **accountability**, where responses to the epidemic are underpinned by learning from experience through periodic situation assessments, analysis and performance monitoring; and
- **commitment**, by substantially increasing those efforts within their mandates and areas of influence which most directly impact on the course of the epidemic.

IV. Leadership Commitments and Core Actions

43. The Global Framework proposes commitments together with a set of essential actions through which leaders and policy makers at global, regional, national and community level can mobilise their societies to more fully respond to the epidemic. Achievement of the overarching aim of the global response requires leadership commitments:

1. To **ensure an extraordinary response** to the epidemic which includes: the full engagement of top-level leaders; measurable goals and targets; effective policies and programmes supported by improved epidemiological and strategic information; adequate and sustained financial resources; and integration of HIV/AIDS prevention and care strategies into mainstream planning and development efforts.

2. To **reduce the stigma** associated with HIV and AIDS and to protect human rights through personal and political advocacy and the promotion of policies that prevent discrimination and intolerance.

3. **To expand efforts to support community-focussed action** on the epidemic by affirming and strengthening the capacity of local communities to be assertively involved in all aspects of the response.

4. **To protect children and young people from the epidemic and its impact** through universal access to quality primary education and increased secondary school attendance, particularly for girls; life-skills education approaches for in-school and out-of school youth; access to youth friendly reproductive and sexual health services; services to prevent mother-to-child transmission of HIV; education on ways to prevent harmful drug use and to reduce the consequences of abuse; and early support to children affected by HIV/AIDS, in particular orphans.

5. **To meet the HIV/AIDS related needs of girls and women** and to address the circumstances that disadvantage women with respect to HIV/AIDS while enhancing their abilities to contribute their knowledge and voice as a force for change. In particular, to address gender-based inequalities in access to information and services and to improve access for women to male and female condoms and voluntary counseling and testing within family planning clinics and other reproductive health settings, and to assure equitable access for HIV infected women to care and social support.

6. **To expand efforts directly addressing the needs of those most vulnerable to, and at greatest risk** of HIV infection. In particular, to advance policies and programmes which promote and protect the health of sex workers and their clients; injecting drug users and their sexual partners; men who have sex with men; refugees and internally displaced persons; and men and women separated from their families due to their occupations or conflict situations.

7. **To provide care and support to individuals, households and communities affected by HIV/AIDS**, ensuring access to voluntary counseling and testing and the continuum of affordable clinical and home-based care and treatment (including antiretrovirals), essential legal, educational and social services, and psychosocial support and counseling.

8. **To promote the full participation of people living with and affected by HIV/AIDS** in the response to the epidemic by ensuring safe opportunities for people to speak out and give testimony to their experience, to participate in national and local advisory bodies, and in planning and implementation of HIV/AIDS programs.

9. **To actively seek out and support the development of partnerships required to address the epidemic** among the public sector and civil society, including the private sector. In particular, to foster those alliances required to improve access to essential information, services and commodities – including access to condoms, care and treatment including treatment of sexually transmitted infections – and to the technical and financial resources required to support prevention, care and treatment programmes.

10. **To intensify efforts in socio-cultural, biomedical and operations research** required to accelerate access to prevention and care technologies, diagnostics and HIV vaccines, and to improve our understanding of factors which influence the epidemic and actions which optimally address it.

11. **To strengthen human resource and institutional capacities required to address the epidemic**, and in particular to support service providers engaged in the response to the epidemic within the education, health, judicial and social welfare sectors.

12. **To develop policies, legislation and programmes which address individual and societal vulnerability to HIV/AIDS and lessen its socio-economic impacts**, by focussing on enabling strategies which operate in the context of overall poverty reduction strategies and human development priorities.

V. The Way Forward

44. The guiding principles, expanded response approach and leadership commitments and essential actions of the Framework for Global Leadership on HIV/AIDS are designed to be universally applicable. While there is a universal need for local, national and international leadership to guide the response to the epidemic, the specific form and content this leadership takes will depend on the particular context of the epidemic in different parts of the world.

45. It is envisioned that the Global Framework will serve to guide the further development of tools for priority setting which can be applied at the operational level, such as those required for the

analysis of social-vulnerability, cost-effectiveness, and programme sustainability. The Framework will also help to shape the development of particular strategies needed across diverse fields and institutions in different settings and at different levels - community, national and regional. The adaptation and incorporation of the guiding principles and leadership commitments within these many strategies will enable each of them to be pursued in greater synergy with one another, increasing the prospects that all of them can be more successful in achieving their specific objectives.

46. Within the United Nations System, the Global Framework will guide the development of the United Nations System Strategic Plan and the institutional strategies for the various Funds, Programmes and Specialised Agencies.

47. It is envisioned that Member States will seek to build on their commitment to achieve major reductions in HIV infection rates among young people with additional commitments at the highest levels to achieve common goals. The Framework for Global Leadership on HIV/AIDS should serve to inform and guide the development of those additional goals and commitments.

48. This Global Framework therefore represents a starting point and a set of guiding principles, rather than the last word in strategic response to HIV/AIDS. Government, political, religious and community leaders, policy makers, people living with HIV/AIDS, and community activists wherever they are located are encouraged to take the Global Framework and use it as a guide in the development and re-evaluation of their own strategies for action.