UNAIDS RST ESA | 2015

Report of the Eastern and Southern Africa Regional Consultation on the UNAIDS Strategy 2016 – 2021

FINAL REPORT

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Abbreviations and Acronyms

ACHPR	African Commission (or Court) on Human and Peoples' Rights
ACP	Africa, Caribbean and Pacific Group of 79 countries
AfriYAN	African Youth Network on Population and Development
AFROCAB	African Community Advisory Board
AIDS	Acquired Immune Deficiency Syndrome
AMSHeR	African Men for Sexual Health and Rights
ANASO	Angola Network of AIDS Service Organizations
AQWCLN	African Queens and Women's Cultural Network
ART	Antiretroviral Therapy
ARVs	Antiretroviral drugs
ASLM	African Society for Laboratory Medicine
BP	Blood pressure
CABSA	Christian AIDS Bureau of Southern Africa
CBO	Community-based organisation
CBR	Community-based rehabilitation
COMESA	Common Market for Eastern and Southern Africa
CRPD	Convention on the Rights of Persons with Disabilities
CS	Civil society
CSE	Comprehensive Sexuality Education
CSO	Civil society organization
CSS	Community systems strengthening
CYSRA	Youth Coalition on Adolescent Sexual and Reproductive Health Rights and HIV/AIDS
DFID	Department for International Development of the United Kingdom
DHAT	Disability HIV and AIDS Trust
DPO	Displaced people's organisations
EAC	East African Community
EANNSO	East Africa National Network of AIDS Service Organizations
ECHS	Early Childhood Household Stimulation
EID	Early infant diagnosis
eMTCT	Elimination of mother-to-child transmission of HIV
ESA	Eastern and Southern Africa
GBV	Gender-based violence
GDP	Gross domestic product
GF	Global Fund to Fight AIDS, Tuberculosis and Malaria
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GIPA	Greater Involvement of People Living with HIV
GP	Global Plan towards the Elimination of New Infections among Children by 2015 and Keeping their Mothers Alive
HBV	Hepatitis-B virus
HIV	Human immunodeficiency virus
HLM	High-level Meeting at the UN
HPV	Human papilloma virus
HR	Human resources
HSRC	Human Sciences Research Council
HUAIROU	Global membership coalition of women's networks, non-governmental organizations and women's organizations

ICF	International Classification of Functioning, Disability and Health
ICWSA	International Community of Women Living with HIV in Southern Africa
IDDC	International Development and Disability Consortium
IDP	Internally displaced person
IGAD	Intergovernmental Authority on Development
ILO	International Labour Organization
INERELA+	National Network of Religious Leaders Living with and Persons Affected by HIV and AIDS, Africa Region
IOM	International Organization for Migration
ISHTAR MSM	MSM organization based in Kenya
JHB	Johannesburg
KELIN	Kenya Legal and Ethical Issues Network on HIV and AIDS
LEGABIBO	The Lesbians, Gays & Bisexuals of Botswana
LENASO	Lesotho Network of AIDS Service Organizations
LGBTI	Lesbian, Gay, Bisexual, Transgender and Intersex
M-health	Health information using mobile phone technology
M&E	Monitoring and evaluation
M2M	Mothers 2 Mothers
MANERELA	Malawi Network of Religious Leaders Living with or Affected by HIV and AIDS
MDGs	Millennium Development Goals
MMC	Medical male circumcision
MNCH	Maternal, neonatal and child health
MSF	Médecins Sans Frontières
MSM	Men who have sex with men
NAC	National AIDS Council
NAP+SAR	Network of African People Living Positively, Southern Africa Region
Option B+	Lifelong ART provision to all pregnant and breastfeeding women living with HIV
PAPWC	Pan-African Positive Women's Coalition
PATA	Paediatric AIDS Treatment for Africa
PATAM	Pan-African Treatment Access Movement
PCB	Programme Coordinating Board of UNAIDS
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
PLHIV	People living with HIV
PLWH	People living with HIV
PMTCT	Prevention of mother-to-child transmission of HIV
PrEP	Pre-exposure prophylaxis
PSM	Procurement and supply management
REC	Regional economic commission
REPSSI	Regional Psychological Support Initiative
RIATT	Regional Interagency Task Team on Children & AIDS
RST-ESA	Regional Support Team for Eastern and Southern Africa of UNAIDS
SABCOHA	South African Business Coalition on Health & AIDS
SADC	Southern African Development Community
SAfaids	Southern African HIV and AIDS Information Dissemination Service
SANAC	South African National AIDS Council
SDGs	Sustainable Development Goals
Sida	Swedish International Development Cooperation Agency

SOGI	Sexual orientation and gender identity
SMART	Specific, measurable, achievable, relevant, time-bound
SMC	Safe male circumcision
SRH	Sexual and reproductive health
SRHR	Sexual and reproductive health rights
SSAC	South Sudan AIDS Commission
SWHP	Swedish Workplace HIV/AIDS Programme
TACAIDS	Tanzania Commission for AIDS
TB	Tuberculosis
TOWA	Total War against AIDS
TG	Transgender
TRIPS	Trade-related Aspects of Intellectual Property Rights
UBRAF	Unified Budget, Results and Accountability Framework of UNAIDS
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNODC	United Nations Office on Drugs and Crime
VIA	Visual inspection with ascetic acid
VL	Viral load
VMMC	Voluntary medical male circumcision
VSO-RAISA	Voluntary Service Overseas – Regional AIDS Initiative Southern Africa
WFoL	Widows Fountain of Life
WFP	World Food Programme
WHO	World Health Organization
WHO IST/ESA	WHO Inter Country Support Team/East and Southern Africa

Acknowledgments

The UNAIDS RST would like to thank all who gave their valuable time, and shared their wisdom, experience, and passion, for this consultation; the participants at the one-day consultation, those who provided written submissions, and those who attended the Treatment Forum and Human Rights Taskforce. Your views and suggestions have been passed on to UNAIDS HQ; and your discussions shared within the region through this Report.

The RST would also like to acknowledge the work done by staff in the RST in design, preparation and conducting this consultation.

1. Executive summary

Overall, the consultation comprised a number of elements, clustered round a one-day Consultation held in Johannesburg on 23rd March 2015. These were:

- Wide dissemination of the UNAIDS Discussion Paper "*Getting to Zero: How will we Fast-Track the Response?*" in the region; this formed the basic platform for all elements of the regional consultation;
- Three constituency-specific consultations: an e-survey of civil society, a Human Rights and Social Justice Eastern and Southern Africa regional consultation, and Eastern and Southern Africa Regional Treatment Forum.
- The International Disability and Development Consortium (IDDC) submitted a draft discussion paper with regard to the pressing need for the better inclusion of people with disabilities.
- The One-day Consultation: this used plenary and group discussions to elicit answers to the five questions from the UNAIDS Discussion Paper across seven themes identified as critical for the region: Prevention, Treatment, eMTCT, Human Rights and Social Justice, Gender, Community Engagement, Political Commitment and Sustainability. In addition a High Level Ministerial Panel deliberated through the day and presented a High Level Political Agenda.

One hundred and seventeen (117) participants from across the region attended the one-day consultation. There were from governments and programmes, civil society, communities, academia, and the UN family. In addition a High Level Ministerial Panel deliberated through the day and presented a High Level Political Agenda.

The final draft report was circulated to all participants from the one-day consultation for review.

The Five questions

The core of the consultation was the attempt by the region to answer the five questions posed in the UNAIDS Discussion paper.

a) What has changed?

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

- The post 2015 SDGs, although not yet finalized, present a new context for the AIDS response as AIDS is not a standalone goal.
- Flat line international resources, competing development priorities, and new priorities for development investment pose challenges for future AIDS investments.
- Some countries in the region are graduating to high-middle and middle income level, limiting their access to international resources.
- **Health and community systems** are not at the same performance level in all countries, and particularly weak in **the fragile states**, where the AIDS response challenges are compounded by security issues and humanitarian crises.

In their detailed discussions, the participants enlarged on further critical changes that have taken place in the region:

- **The biggest contextual change in the region is the expansion of ART, with 8.1 million people on treatment and 78% PMTCT coverage.** This is having an impact in many ways: the perception of HIV/AIDS as incurable has changed as PLHIV on ART lead normal lives; health services have been challenged and in many ways transformed by the demands of treatment. These challenges and changes will continue with the need to improve retention and adherence, and to ensure people maintain an undetectable viral load.

- **Of particular importance and concern for the region, however, is that while new infections have gone down in all countries, the face of HIV has changed - it is now predominantly a young woman—and adolescents:** 50% of the deaths from AIDS are among adolescents. In 2013, HIV incidence across countries in the region was high among women in their late teens and early 20s**.**

- **With respect to gender, there have been significant improvements in gender awareness, understanding of the role gender plays and the need for gender equality, and gender-sensitive planning and programming:** both in general, and specifically with regard to HIV - but there is still far to go.

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

- **Decentralisation is increasing throughout the region:** and there are advantages of decentralization but also challenges. Decentralisation will require major administrative, bureaucratic, legal and regulatory system changes; how can these be achieved without risking the gains of present systems?

- **At both regional and global level there has been an increased recognition of the need to integrate human rights, social justice, participation and equity within broader goals for universal health coverage.** These are among the 'critical enablers' of HIV programming, and thus provide scope for improved, and more focused interventions; there is still a long way to go, however. Political commitment, evidence to inform good policy-making, and social transformation will all be needed if these gains are to be realised.
- **Decreased donor funding has highlighted critical sustainability issues**. While some countries can well afford to allocate more of their domestic resources for HIV and AIDS, some will continue to require long-term external support.

b) What can we build on? Who is being left behind and why?

- A number of prevention programmes have been successful around the region. But much better evidence of just how these prevention programmes work, and what aspects work best, is required. We need to ask what prevention programmes have not been successful, and do less of such activities; and what works well, and do more.

- But many people including key populations, adolescents and communities in remote and hard to reach areas are being left behind: internal mobile populations, young people not in school, young people at 'hot-spots' of highly risky behaviour, girls and young women at risk of sexual abuse and violence, MSM, TG and sex workers, traditional leaders as role models, workers in the informal economy, persons with disabilities. Prevention programmes need to become more focused and targeted at these groups.

- HIV testing remains low despite rapid scale up - only 45% of people living with HIV know their HIV status and only 10% of young men and 15% of young women (15–24 years) were aware of their HIV status in 2013.

- Only 41% of all PLHIV in the ESA region were on treatment at the end of 2013, with significant variation in coverage among countries and within countries. People are being left behind in the roll-out of treatment: people with disabilities, those living in remote areas (such as fishing sites), refugees and IDPs who are afraid to access services, adolescents in boarding schools, prisoners and women who do not normally access health services, even for delivery.

- The great growth and empowering of civil society and community level engagement is a vital area to build on and take forward. Community structures of various kinds have been developed and need to be built upon to support issues of adherence, stigma demand creation, advocacy, engagement and accountability. In addition, community-driven prevention regarding cultural norms and practices is something that can be done effectively through community level engagement and by the civil society.

- Key drivers of the epidemic for women and girls, are grounded in cultural norms and practices, are multi-layered and mutually reinforcing--but also preventable: these drivers include the unequal relations between women and men, and socio-cultural norms and practices. The lack of awareness, visibility and commitment to gender equality, harmful gender norms, women's and girl's agency and empowerment, sexuality, and the elimination of gender-based violence was highlighted.

- There is increased understanding and evidence of structural drivers and the role of human rights, social justice, participation and equity in responses to HIV in the region. There remain, however, significant gaps in the evidence, understanding, inclusion and prioritisation of specific populations (e.g., MSM, transgender populations, sex workers, people who use drugs, adolescents and children, women, people with disabilities, migrants and refugees). There are gaps in strengthening platforms for broader social justice movements as well as significant gaps in

allocation of resources and implementation of concrete actions (e.g., law review, social protection) to strengthen the rights of key populations and promote human rights, social justice, participation and equity.

c) What should be the region's strategic priorities be?

- **Addressing the needs of adolescents and young women and girls** is a vital priority.
- For treatment the most important thing is to **strengthen the health systems to build upon the scale up of treatment that has occurred.**
- **Continuing to build evidence across the board** is a priority to ensure focus, impact and effectiveness of investment.
- **Increased political commitment and leadership** on the "hard issues" is needed**;** as priorities change, political commitment must be sustained.
- **We need a new commitment to change, which does not require financial investment,** to address socio-cultural issues, norms and practices with regard to young people and wome**n.**
- **Addressing the needs of key populations is essential.** A prioritized strategic approach needs to advocate for the explicit inclusion of such key populations into all parts of HIV prevention: behavioural interventions, condom promotion, and accessibility of information, medical male circumcision and prevention of mother-to-child transmission.
- **A number of opportunities to address sustainability issues were identified:** some countries can afford to invest more of their domestic resources; some cannot; all must try to be more efficient and effective in their investments.

d) What are the "game-changers"?

The main 'game-changer' will be to focus on ensuring **effective implementation and service delivery of the right programs, at the right place, for the right people, at the right time**.

- **Re-invigorating prevention**: Success or failure in preventing sexual transmission in the region is the defining factor; prevention of sexual transmission must be re-vitalised and focused where new infections are taking place. We need both specific prevention programmes (e.g., comprehensive sexuality education, condom distribution, etc.) and broader programmes that address the drivers and underlying norms—to 're-socialise' boys and young men, empower girls and young women, and recalibrate the mind-sets of adults and leaders.
- **Investing in young people, with a particular focus on young women and girls** is vitally important. A number of new initiatives have started – "All In", recently launched

under the leadership of UNICEF, will expedite the response for adolescent in the ESA countries; PEPFAR launched in December 2014 the “Dreams” initiative to accelerate implementation of programs for young women and girls in several countries in the region. Comprehensive sexuality education is gathering momentum; this will help address structural factors at community level to reduce gender-based violence, ensure gender equality and build resilient, educated and independent young women.

- **Key populations** – sex workers, gay people and men who have sex with men, injecting drug users, migrants and others left behind remain a sensitive topic, and much more must be done to ensure access to health and social services for these groups. We have to make the commitment of states to equality, and universal access to services, a reality for these populations, pragmatically managing the social, cultural, economic and legal obstacles.

- **Urbanization** is an evolving phenomenon in ESA countries that brings development and vulnerabilities. Cities in many countries are not only disproportionally affected by the HIV epidemic but often have large informal areas in which HIV prevalence is often high with heightened vulnerabilities.

- **Effective and efficient service delivery is at the core of successful implementation.** Strengthening all aspects of health systems is needed: working for integration and greater efficiency in service delivery, getting better, localised allocation of resources, building greater community linkages and participation, will all be critical.

- **Political commitment at all levels and resources is essential.** Leadership, both central and local, both traditional and institutional must be mobilised and sustained. Communities must be mobilised to ensure the quality of services, and to hold service delivery accountable.

- **Sustainability, partnership and shared accountability of the AIDS response** are essential. We need to follow two paths: be more effective with available resources and develop innovative financing mechanisms: such as the new initiative between SADC Ministers of Health and the private sector in establishing a Health Trust Fund.

e) How can UNAIDS support the region?

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

- Another key role for the UN will be **capacity strengthening and technical support** at national level, to amplify local voices, build accountability, and strengthen coordination.

The UN can create space for young people (especially young women and girls) to contribute and participate. This is also needed at regional level, facilitating platforms to bring a range of organisations and sectors together, with high-level advocacy for sustainable financing and ownership, and accountability for action.

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

- UNAIDS should use its **convening role** to bring together the diverse partners and use the credibility of the UN/UNAIDS to influence political leaders. Leaders can time their advocacy to before or after elections.

From the high-level ministerial group and panel:

- We have to recognise **key populations and work through the structures that bring services closer to these populations.** We need to develop formal contracts with civil society organisations to implement programmes, which governments should fund.

- **Focus on local-level HIV epidemic dynamics**

- The Southern African Development Community (SADC) and the Intergovernmental Authority on Development (IGAD) should bring **common cross-border issues to the ministers as a joint agenda**: "Let's have one common and formalised agenda" for all the cross-border issues (truck drivers, fisher-folk), zooming in on the specific communities."

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

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

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

Key Messages from the consultation

- The expansion of treatment has transformed how the epidemic manifests, is perceived and is responded to in the region.
- Curbing sexual transmission among young people, particularly girls and young women, is vital: without this the epidemic will remain.
- A comprehensive approach to sexuality education, along with longer-term approaches to address cultural norms and factors underlying gender inequalities, is essential to empower your people to identify, sustain and expand effective responses to HIV.
- Key populations remain under-served, under-involved and under-represented.
- Communities and civil society have had, and will continue to have, key roles in expanding and sustaining prevention, treatment, empowerment, and accountability. They must be supported.
- Political commitment for the hard choices, and for sustainability, remains essential; innovative ways must be identified to sustain this.

Way Forward

A clear demand emerged from the consultation, for a specific ESA Regional Strategy; not just some regional specificity within a global UNAIDS' strategy, but rather a specific strategy derived from regional realities, based on a broad regional consensus, owned by the region, driven by the region, and to which all partners in the region can be held accountable.

A number of steps can be taken immediately towards the development of this strategy:

1. Circulation and validation of this consultation report.
2. Establishment of a taskforce to revive the partnership platform.
3. Convening, using this platform, of a taskforce to develop a regional strategy.

2. Introduction and background

2.1 The HIV response in the region: Overview

East and Southern Africa is the region of the world that is worst affected by the HIV epidemic; it currently accounts for about 50% of the global HIV burden. The region has made significant progress, however, in the response to the epidemic in recent years and by mid-2014, more than 8.1 million people, out of a total of 18.5 million people, living with HIV in southern and East Africa were receiving antiretroviral therapy (ART).

The rates at which treatment and prevention programmes have been scaled up, and the associated declines in incidence and mortality, have varied substantially among countries

but overall have led to a substantial decline in the total number of new HIV infections and AIDS-related deaths in the region.

East and Southern Africa Region 2013	
Number of people living with HIV	18.5 million
Number of children living with HIV	2.0 million
Number of new HIV infections	1.1 million
Number of new HIV infections among children	120 000
Number of AIDS deaths	730,000
Number of people receiving ART	8.2 million

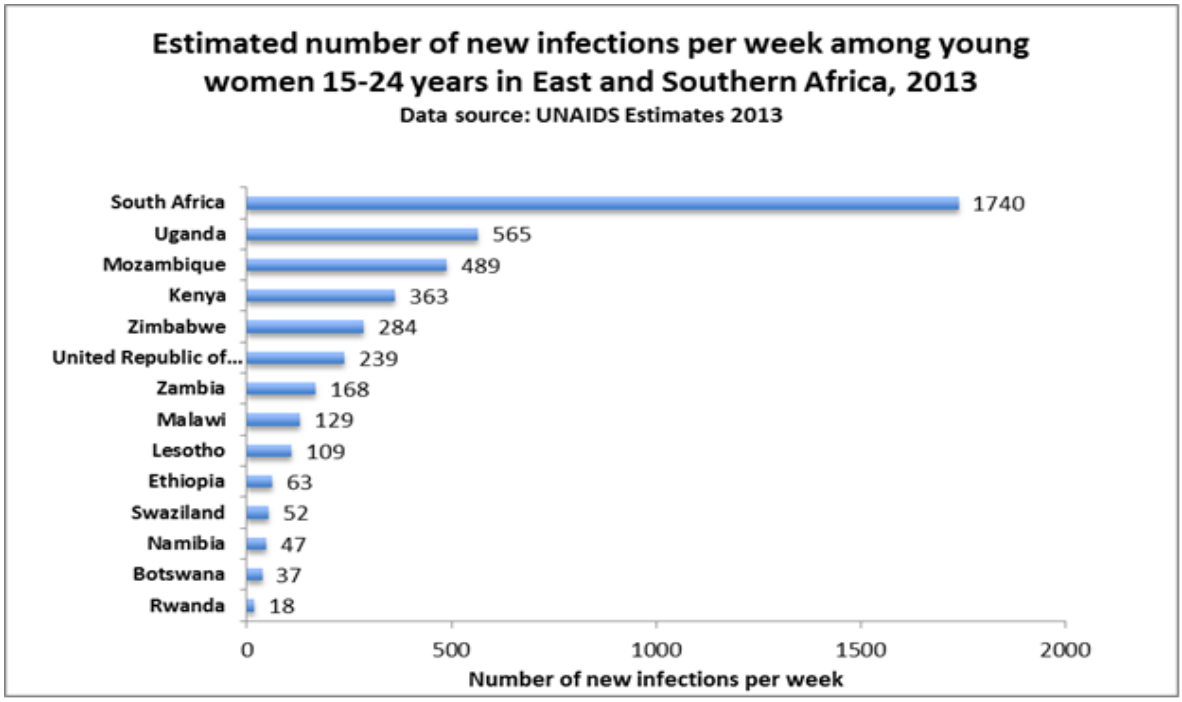
The region is on track to reach several of the United Nations Political Declaration targets, including the elimination of new HIV infections among children, reaching the universal access target for treatment provision to people living with HIV, halving TB deaths among people living with HIV, and eliminating travel related restrictions for people living with HIV.

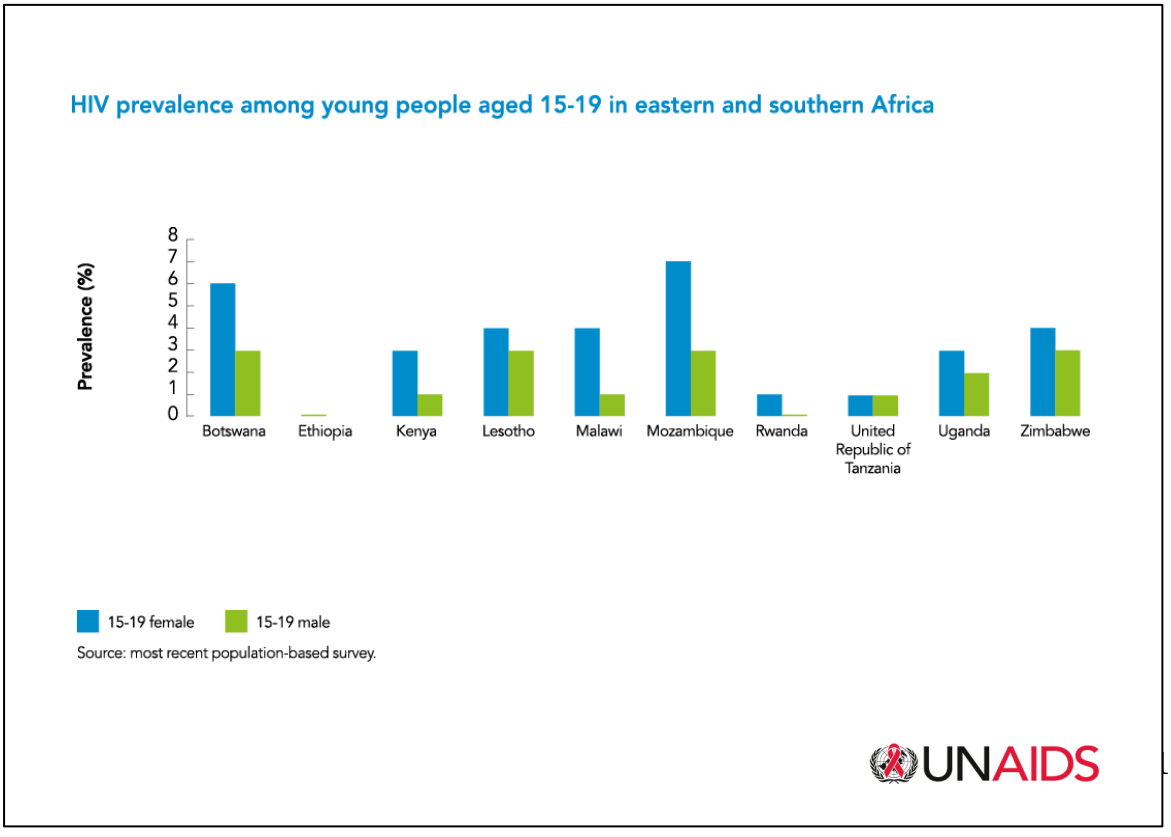
Specific areas of progress include:

- The number of new HIV infections in ESA has fallen by 32% between 2005 and 2013.
- ART has been scaled up significantly and by mid-2014, more than 8.1 million people living with HIV in the region were receiving treatment (coverage of 44%). This scale-up has led to a decline in AIDS-related deaths of 46% between 2005 and 2013.
- All countries in the region have adopted the 2013 WHO treatment guidelines and are committed to starting treatment at a $CD4^+$ cell count of 500/□L. Some countries, for example Zambia, are considering a policy of starting people on treatment as soon as they are found to be HIV positive.
- Coverage of PMTCT services among pregnant women living with HIV reached 78% in 2013. As a result of this dramatic scale-up of PMTCT services, new infections among children have fallen by 66% between 2005 and 2013 and the region is on track to reach the elimination target.
- An increasing number of countries in the region are developing Investment Cases in order to be more strategic in the allocation of resources and to ensure that the HIV response is efficient and sustainable.
- All countries in the region are in the process of setting new targets for the HIV response for 2020 and 2030. The UNAIDS treatment target of 90-90-90 (90% of people living with HIV to know their status, 90% of those to be on treatment, 90% of those to be virally suppressed) has been endorsed by the SADC and EAC economic communities and have been adopted in the majority of countries in the region.

2.2 Prevention

Despite these gains, however, there are worrying trends in the region. Half of new HIV infections worldwide occur in ESA region. Of particular importance and concern for the region is the high rate of new infections among girls and young women. In 2013, HIV incidence across countries in the region was high among women in their late teens and early 20s. This equated to 4300 new HIV infections among young women aged 15-24 years per week among 14 ESA countries.

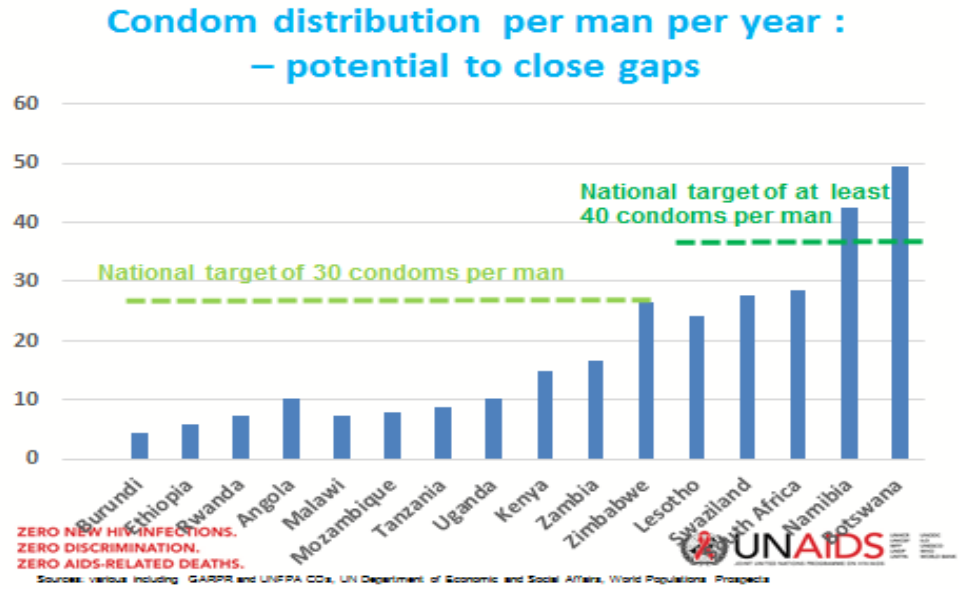


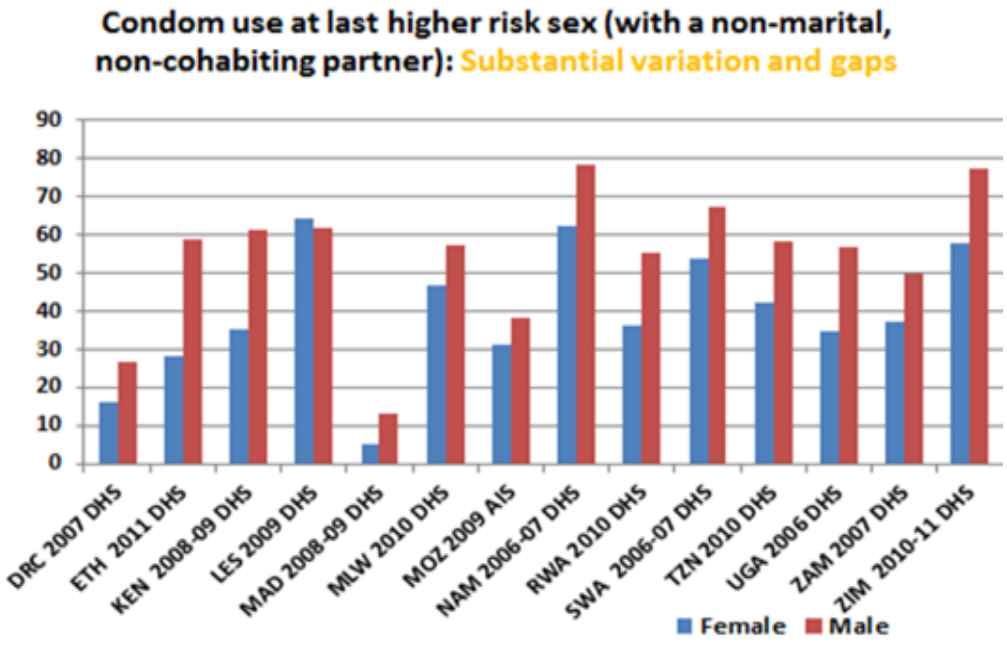


New HIV infections among populations such as men who have sex with men, sex workers, people who inject drugs, and transgender people contributed 12% of total new HIV infections in Swaziland; 20% in Mozambique; 25% in South Africa; and 30% in Kenya. HIV remains the single largest cause of life-years lost in the ESA region.

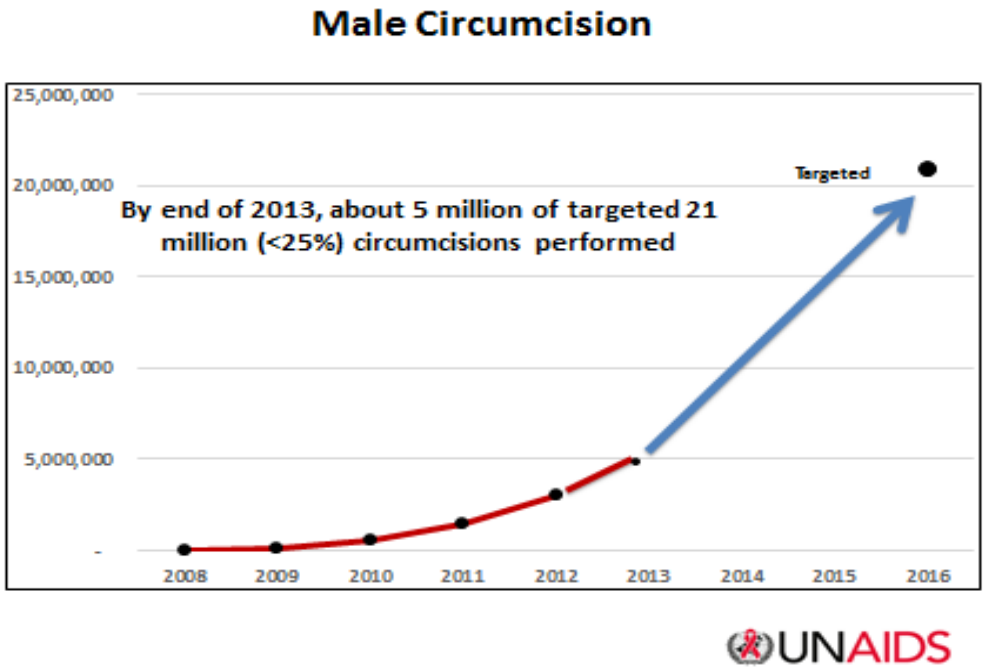
There is also cause for concern in relation to HIV risk behaviour: in 2013, Ethiopia, Rwanda, South Africa, Uganda, the United Republic of Tanzania and Zimbabwe reported significant increases in the number of sexual partners. Consistent condom use overall remains low in the region and there are significant gaps in condom availability. Among young people, access to condoms is especially poor.

Only 2 in 15 countries in ESA region met a regional benchmark of 30 condoms per man per year; and there is substantial variation in condom usage.





Countries are investing resources in VMMC; however, uptake and demand remains low, with only five million men/boys circumcised thus far against a target of 21 million by 2015.

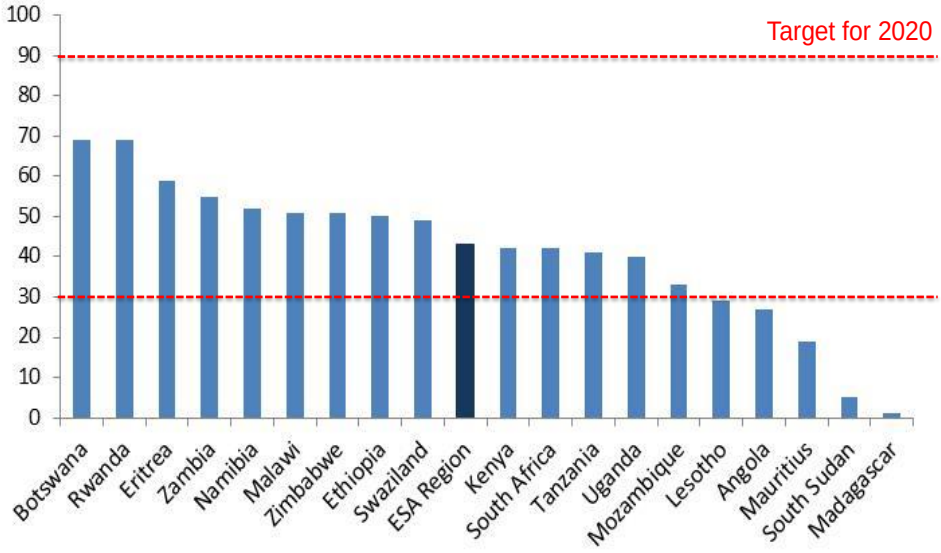


Modelling studies have indicated that 80% coverage of HIV treatment by 2015 would reduce new HIV infections by 30-50%. However, treatment coverage for the ESA region is currently at 43% with significant variations by country.

HIV prevention is often implemented with weak strategic information, however: this limits target group prioritization based on evidence, and geographical prioritization based on evidence, leading to inadequate focus on high impact basic programmes.

2.3 Treatment

There has been good progress in treatment coverage although some countries lag behind.



The region has embraced the new 90-90-90 targets for HIV treatment, and countries have used various opportunities and entry points for the integration of these targets into national processes, such as the development of Global Fund concept notes, development of investment cases, review of National HIV Strategic Plans and review of 2015 Political Declaration targets.

HIV testing remains low despite rapid scale up - only 45% of people living with HIV know their HIV status and only 10% of young men and 15% of young women (15–24 years) were aware of their HIV status in 2013. Many HIV testing opportunities are missed and often fail to reach those populations who are less likely to use mainstream health services, such as key populations, people with disabilities and people living in remote or hard to reach areas. Rapid scale up of HIV testing through innovative approaches including provider-initiated testing, community-based testing campaigns and door-to-door HIV testing campaigns is urgently needed. HIV self-testing technologies have been found to be accurate and are preferred by many, especially among those least likely to access other testing delivery channels.

Progress has been slow in the adaptation and implementation of the 2013 WHO treatment guidelines in some countries, which has resulted in delays in treatment scale up. Health systems are strained to support increased demand for testing and treatment (including human resource management, procurement and supply management, transport of samples, data management, financial resources, and provision of services for early infant diagnosis). Stock-out of commodities including HIV test kits undermines HIV testing and treatment scale up. Community systems to support the treatment cascade are also slowly developing.

Continuing strengthening of health systems in the region is focusing on:

- The availability, quality and use of strategic information for evidence informed programming and policies, mapping geographic locations with high transmission rates and populations at higher risk of infection (including those left behind in HIV services) to better focus HIV programmes.

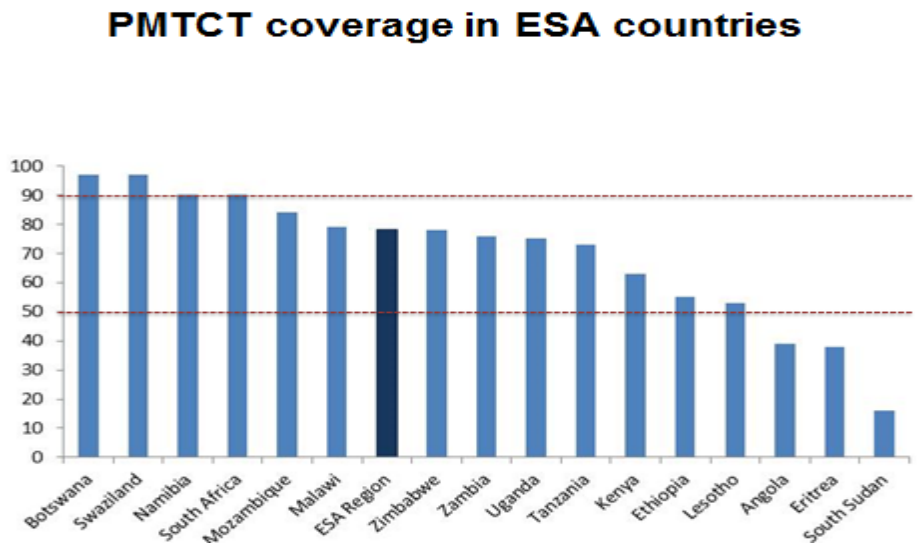
- Simplifying the treatment cascade, from HIV testing, treatment and care, to viral load testing to improve access to and delivery of services, and adherence to treatment regimens in order to reach the 90-90-90 targets.

- Service integration, task shifting and decentralization of HIV testing and treatment services for a more effective continuum of treatment care and support.
- Community mobilization and engagement to support and improve access to HIV testing and treatment services, to promote adherence to treatment regimes, and to reduce the burden on overstretched health services.
- The development of simplified, more affordable, and more effective drugs including paediatric formulations and point-of-care diagnostics.
- Addressing barriers for adolescents and young people to access HIV testing and treatment service, including age of consent, service provision and integration of HIV and SRH services.

Innovation is needed to strategically focus and deliver services and to effectively reach those at greatest risk of HIV infection if the region is to reach the Fast-Track Targets. While fast-tracking of the HIV response is necessary in all countries, priority should be given to the 13 high burden countries in the region which, along with other countries across the world, account for 89% of all new HIV infections worldwide.

2.4 eMTCT

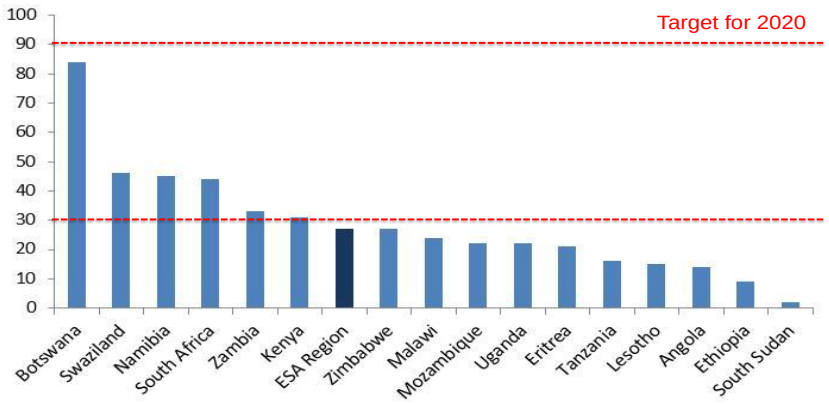
There has been a 43% decline in new HIV infections among children in the 21 Global Plan (GP) priority countries (15 global plan countries are in ESA region) from 360,000 in 2009 to 199,000 in 2013. Malawi has had the largest decline in MTCT by 67%, while 7 countries (Botswana, Ethiopia, Malawi, Mozambique, Namibia, South Africa and Zimbabwe) had a decline of 50% or more. Angola and Lesotho recorded the lowest decline of less than 25% in the region.



During the past five years, there was 29% decline (43% since 2005) in the number of AIDS-related deaths among women of reproductive age.

Eight countries achieved MTCT rate <15% by 2013 (Botswana-2%, South Africa-6%, Namibia-10%, Swaziland-10%, Mozambique-12%, Malawi-13%, Zimbabwe-13%, Uganda-13% and Zambia-15%). Three countries (Botswana, Namibia and Zambia) have already met their national target of providing ARVs to 90% of all HIV-infected pregnant women in order to prevent mother-to-child HIV transmission. Four countries (South Africa, Mozambique, Swaziland and Zimbabwe) are approaching the 90% ARV coverage target. Only two countries (Botswana and South Africa) have reached the 2015 target of reducing vertical transmission of HIV to 5% or less.

Paediatric ART has increased in all countries although it remains very low compared to adults; overall only 27% of children living with HIV in 2013 were receiving ART. Of particular concern is weak case finding of HIV-infected children, low uptake of paediatric ART and high rates of loss to follow up.



Only 2 countries (Botswana and Namibia) have reached the universal access target of initiating ≥80% of eligible children on ART in 2012. Four countries (Namibia, South Africa, Swaziland and Zambia) are providing timely early infant diagnosis (EID) to more than 50% of HIV-exposed infants. Identification of pregnant women and children living with HIV has improved, with 7 countries reporting HIV testing and counselling rates of pregnant women in ANC of > 90% (2013). Similarly, maternal ARV Coverage and mother-infant pairs receiving ARV prophylaxis has improved. All countries in the region have adopted Option B or B+.

Health systems are slowly addressing these challenges through greater integration of HIV reproductive health and maternal and child health services. Many mothers and children are left behind, however, through poor access to essential health services (antenatal and postnatal care, childhood immunizations and family planning) by poor households, PLHIV, and adolescent/young women.

There remain many missed opportunities to identify HIV-positive children (TB wards, malnutrition clinics, childhood immunizations, family planning clinics and adult ART clinics). Implementation of Prongs 1&2 continue to lag behind resulting in continued demand for PMTCT. There is high HIV transmission during breastfeeding: while 6-week MTCT rates are 7%, this rises to 16% after breastfeeding. Similarly paediatric care is lagging behind, with weaknesses in EID, case finding of HIV-infected children, infant follow-up and linkages between EID and ART services, low uptake of paediatric ART and high rates of loss to follow up.

2.5 HIV in the cities of the region

Urbanization is an evolving phenomenon in the countries of the region that brings development, and vulnerabilities. Cities are disproportionally affected by the HIV epidemic. In six countries in the region (Malawi, Mozambique, South Africa, Tanzania, Zambia and Zimbabwe) more than 14% of all PLHIV are estimated to live in the main cities; in Malawi, South Africa and Zambia more than 20%; 16% in South Africa live in Johannesburg alone. Five cities in South Africa (JHB, Durban, Pretoria, Cape Town, Port Elizabeth) account for 30% of all South Africans living with HIV. Cities often have large informal settlement areas in which HIV prevalence is often high and which often raises humanitarian concern. For example, Nairobi urban slum growth is estimated at 5% per annum, which makes it the highest rate in the world; within Nairobi slums, HIV prevalence is estimated at over 12% (double the national average) – and increasing.

2.6 Civil Society

Civil society and community engagement continues to play a vital role in the response. Civil society and community structures of various kinds have developed. These need to be built upon to support issues of adherence, stigma, and demand creation. But community engagement is more than simply a tool for greater participation in care and prevention services: communities have key roles in advocacy, engagement and accountability. Prevention, for example, is often a question of services and interventions by service-providers and civil society. But, community-driven prevention regarding cultural norms and practices is something entirely different, and can have practical applications to such issues as gender and sustainability.

2.7 Gender

Gender remains a major issue, increasingly visible and recognised; though still highly neglected. There remains a lack of awareness, visibility and commitment to gender equality, harmful gender norms, women's and girl's agency and empowerment, sexuality, and the elimination of gender-based violence. While there has been some progress with gender responsive policies and legislation, political commitment, strategic information, and economic empowerment programmes (such as social protection, cash transfers, livelihood interventions), all these need to be substantially strengthened. Adolescents and young women and girls, particularly girls not in school, are especially neglected.

2.8 Human rights and social justice

There is increased understanding and evidence of structural drivers and the role of human rights, social justice, participation and equity in responses to HIV in the region. Some levels of increased commitment and integration of these can be seen in national, regional and global strategies, policies, plans, programmes and interventions; and some successes in improving human rights, social justice, participation and equity. There remain, however, significant gaps in the evidence, understanding, inclusion and prioritisation of specific populations (e.g., MSM, transgender populations, sex workers, people who use drugs, adolescents and children, women, people with disabilities, migrants and refugees). There are gaps in strengthening platforms for broader social justice movements as well as significant gaps in allocation of resources and implementation of concrete actions (e.g., law review, social protection) to strengthen the rights of key populations and promote human rights, social justice, participation and equity.

2.9 Political commitment and sustainability

Political commitment has been a cornerstone of the AIDS response in the region: ensuring that political decision-makers understood the nature of the problem the epidemic posed, grasped its urgency, and mobilized and allocated resources to address it. Across the region, this has been very successful: nowhere is there still the 'denial' that HIV faced in its early years; all countries have substantial HIV programmes, many of them explicitly multi-sectorial; resources on a very large scale, both domestic and external, both financial and institutional, have been allocated over the years to the epidemic; and remarkable impact has been achieved.

Several important broad changes are taking place in the region, however, that affect the necessary political commitment to fast track the AIDS response. A new development environment, as exemplified in the Sustainable Development Goals (SDGs), is suggesting a re-alignment of the health sector: more holistic, more partnership-based, with new priorities, where HIV and AIDS will be a small part of the health goals. There is a growing attention to and awareness of human rights and rights-based governance, accountability, participation and engagement of citizens; countries are struggling to accommodate this within traditional, state-driven, service delivery models. In a number of countries there is increasing decentralization and devolution of government and services, involving new mechanisms for governance.

While these will theoretically bring resource allocation, services and accountabilities closer to communities, there is a risk of a period of slowing implementation while governance mechanisms are developed and put in place. There is a growing recognition of the changing epidemiological realities and analysis, making HIV programming more granular, more focused, more targeted. Political decision-makers must and will respond to these changes in their environment; they will thus impact on political commitment.

A critical element in the political commitment of countries in the region is the increasing focus on shifting from reliance on international funding to sustainable domestic funding. Over the coming decade, Africa's GDP is expected to grow by an average exceeding 6% per year, outstripping that of any other region in the world. According to the World Bank most African countries will achieve middle income status by 2025. The challenge for the region is to leverage this growth to deliver additional resources for the health sector.

Analysis to date demonstrates that the over reliance on external resources can be broken in most countries, and that the funding gap can be reduced by implementing the following strategies in combination:

- Increasing government allocations to health and HIV
- Implementing viable innovative funding mechanisms
- Focusing on efficiency in the allocation and use of resources.

The SADC Sustainable Financing Analysis for Health and HIV and the Framework of Action recognises that the application of these strategies will be context specific, and largely dependent on the fiscal capacity and economic performance of individual countries. It recognises that some countries will not be able to fund their own responses. The analysis shows that low income countries in SADC will have financing gaps larger than 5% of GDP till 2024/5 and that even with additional domestic funding, they are likely to struggle to close the funding gap and will continue to require external support. Whereas most of the lower-middle and middle income countries have the fiscal space to allocate more funds to their AIDS programmes.

The potential revenue that could be generated domestically from taxation (on remittances, mobile phones, alcohol and airlines) can be calculated. While the potential and desirability of innovative sources varies from country to country, if all SADC countries implemented innovative financing mechanisms, they would raise about $14billion in 2024/5.

Sustainable financing alone is not enough to achieve an accelerated response, however. Effective and efficient health systems are required to deliver quality health services

affordably. The current state and pace of growth of the health systems in the region, unless addressed, will have negative implications on the fast-track agenda. Countries will have to unblock health systems' inefficiencies as well as address specific challenges related to ARVs, human resources for health, integration etc., which are central to effective service delivery.

3. Aims of consultation

Inspired by unprecedented progress in the last decade, the international community has embraced the ambition of ending the AIDS epidemic by 2030. Front-loading investments and quickening the pace over the next several years, however, will be critical, as demonstrated and advocated by the Fast-Track initiative.

The Fast-Track aims to achieve the '90-90-90' treatment targets *(90% of all people living with HIV will know their HIV status; 90% of all people with diagnosed HIV infection will receive sustained antiretroviral therapy; 90% of all people receiving antiretroviral therapy will have viral suppression)*, and reduce the number of new HIV infections to 500,000 per year by 2020, as well as work towards zero stigma and discrimination.

As the end date of the UNAIDS 2011-2015 Strategy nears, the UNAIDS Programme Coordinating Board has requested its Executive Director to undertake a consultative process to update and extend the existing Strategy in order to Fast-Track the response over the period 2016-2021, in the context of reaffirming and building upon:

- The UNAIDS Vision of zero new HIV infections, zero discrimination and zero AIDS-related deaths, and

- The 3 strategic directions and 10 goals of the UNAIDS 2011-2015 Strategy: 1) Revolutionize HIV prevention; 2) Catalyse the next phase of treatment, care and support; and, 3) Advance human rights and gender equality for the HIV response.

In order to arrive at a revised and ambitious global strategy that mobilizes political commitment, focuses resources and accelerates progress, UNAIDS aims to host a global consultative process that is as inclusive and substantive as possible. The participation of representatives of networks of people living with HIV and other key populations, government, private sector, faith-based organizations and international organizations will be critical.

In line with this intention, the UNAIDS RST-ESA has organised an inclusive consultation process across the region, including thematic, country and regional consultations.

The aims of this consultation were:

a) Key stakeholders in ESA identify key priorities and strategies to fast track the HIV response in the ESA region for the period 2016-2021 and provide input to the UNAIDS Strategy 2016-2021.

b) Key stakeholders mobilized and a regional partnership strengthened to *"Fast track the AIDS response"*.

4. Methods, processes and programme of the consultation

Overall, the consultation comprised a number of elements, clustered around a one-day Consultation held in Johannesburg on 23rd March 2015. These are described in the sections below.

4.1 UNAIDS HQ Discussion Paper

The UNAIDS Discussion Paper, "*Getting to Zero: How will we Fast-Track the Response?*" prepared in Geneva for the consultation on the UNAIDS Strategy 2016-2021, was widely disseminated in the region, and formed the basic platform for all elements of the regional consultation. The Paper asks five key questions to be explored by the consultations:

a) How will developments – globally and in the region – impact the epidemic and response in the region, in countries and at the sub-national level over the next six years?

b) What achievements of the regional response should be expanded and built upon? Where are the main challenges and gaps? Who is being left behind and why?

c) In order to reach the Fast-Track targets, what should be the region's strategic priorities in the response?

d) What will need to change in support of those priorities? What are the "game-changers" – in terms of policy and law reform, funding, resource allocation, partnerships, service delivery, empowering civil society, science and innovation, and links with other health and development efforts?

e) What are the most critical ways in which the UNAIDS Joint Programme can support efforts in the region to end AIDS as a public health threat by 2030?

These five questions became the basis for all the various elements of consultation conducted in the region – see next sections.

4.2 Constituency and country Consultations

To enrich the one-day consultation, three constituency-specific consultations were organised: an e-survey of civil society, a human rights and social justice consultation, and a regional treatment forum. The International Disability and Development Consortium (IDDC) submitted a draft discussion paper with regard to the pressing need for the better inclusion of people with disabilities. A number of country consultations were also held.

4.2.1 Civil society e-survey

In early March 2015 an e-survey of civil society partners was conducted. Fifty-five organisations were contacted, based on their work in the region, networks and linking organisations, of whom 25 responded. The survey used the 5 questions from the UNAIDS Discussion Paper.

An interim report of the e-survey is available at the RST. Some highlights are given here.

Civil society organizations feel that the shrinking envelope of external funds for HIV will have far-reaching consequences for the response in ESA. There is also receding political will to address the epidemic as evidenced by the AU position on the post-2015 agenda. HIV is no longer the threat to development that it was before, due to the progress made in treatment. The persistent high level of new infections in young girls and women, however, and the vulnerability of older people and people with disabilities can only be fully addressed at the community level as they are largely driven by socio-cultural factors.

The legal environment in most countries is still not conducive. There has been an increase in policies around criminalisation of HIV infection as well as same-sex relationships. In some cases, stiffer penalties have been proposed than were found earlier, indicating that there is growing misinformation and intolerance.

The pooled procurement initiative by both SADC and the EAC, the regional harmonisation of registration of medicines as well as the commitment to use TRIPS flexibilities by both regional blocs is a great step forward in ensuring access to affordable medicines in the region, including ARVs.

Weak health systems are the biggest challenge that affects the expansion of the HIV response in ESA. This includes an inadequately prepared health work force and slow rate of task sharing and task sharing. HIV services are still heavily health facility focused and little investment has been made in building other alternative service delivery mechanisms and models.

The e-survey identified a number of **populations left behind** in the AIDS response in the ESA region, and the reasons why. These included: women in general, and particularly young women; men who have sex with men, drug users, sex workers, prisoners, youth, fisher folk and nomadic populations, and people with disabilities.

The following were the **main priorities** identified:

- **Put people at the center:** The AIDS response is about people. “Having the most comprehensive health services to deliver the most cutting-edge drugs means nothing if people don’t have access to those services”.

- **Mobilize culture and communities**: “Rather than diminishing cultures that struggle with stigma, the AIDS response must aim to strengthen community systems so that they can organize their own change.”

- **Simplify the architecture and strengthen accountability**: The current global architecture of the AIDS response, built for a previous era, must be transformed into a more inspiring and simplified model to enhance navigation and accountability.

- **Expand the treatment programme** while addressing existing inequalities that exist both in geographic and population reach.

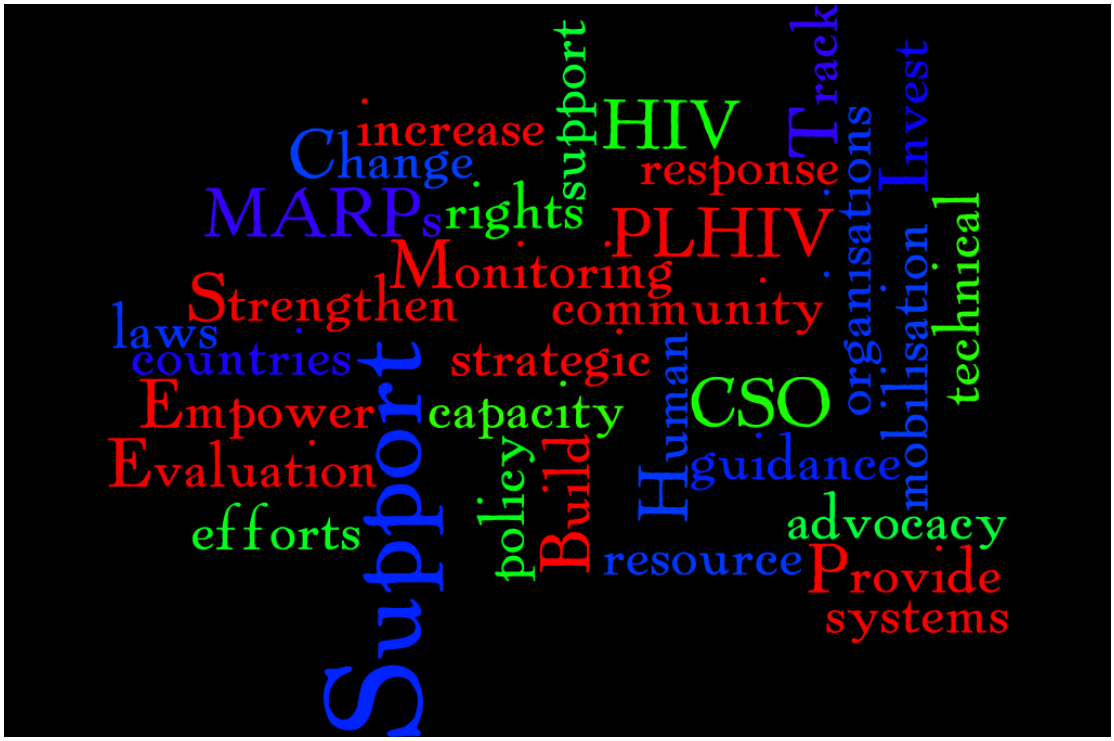
- **Ensure financing of the HIV response** including addressing existing inefficiencies in the response.
- **Strengthen interventions targeting women and girls** in HIV programmes and continue the promotion of a gender-sensitive approach.
- Design specific interventions for and with **key populations and other vulnerable groups.**
- **Strengthen community health systems** where primary health care adequately supports clinical care.
- **Share responsibility and stand in solidarity:** The global community must continue to build on past efforts to share responsibility and stand in solidarity.
- **Elevate health as a force for social transformation:** “Unless countries continue to innovate and re-think healthcare solutions, the sustainability of global health is in doubt.”

Some of the suggestions on the **changes** which need to happen to reach the fast track targets and **game changers** for the ESA region were:

- **mHealth** - **Explore and invest more in technology** for prevention and also to improve adherence.
- **Integration is critical** for all countries - stimulate policy, funding and resource allocation towards integration.
- Identify **new sustainable sources of funding** that are local or regional.
- **Improve prevention measures**: condom and lubricant provision, voluntary medical male circumcision, EMTCT/PMTCT, and others to reach every inhabitant of the region and establish follow-up strategies that involve community health workers to **decrease loss to follow up**.
- **Design and implement HIV programmes targeting key populations** and other vulnerable populations in countries that don’t already have these programmes and strengthen these programmes where they already exist.
- Reinforce the promotion of gender, sexual and reproductive health and rights to **empower women** to make important health decisions on their own.
- **Reinforce monitoring and evaluation systems** and community health systems.
- There is an urgent need to **capacitate civil society** to conduct some of the crucial activities necessary for the success of the 90-90-90 targets, including follow-up of patients on ART and rolling out treatment literacy at the community level.
- It is crucial that countries "**follow the science**" by rapidly encompassing interventions that are proven to be successful.

- Policy and Law Reform- ESA countries should **embrace non-discriminatory policies and laws** so that all populations can be easily reached with all services.

Derived from the e-survey, below is a Wordle presentation of how CSOs see UNAIDS support during the fast track period.



4.2.2. Human Rights and Social Justice

Following a regional consultation on HIV human rights and social justice which took place in November 2014; leading human rights and social justice experts, advocates and activists from the Eastern and Southern African region and beyond gathered in Johannesburg from 18-20 March, for the first meeting of the Think-Tank on HIV, Health and Social Justice.

Members of the Think-Tank include advocates and activists on human rights and social justice, justices, lawyers, members of key population networks and organisations, academics, and law and policy makers.

The members of the Think-Tank have come together with the shared recognition that Africa--and the world--is entering a decisive phase in the response to HIV where human rights gains may be under significant threat at the very moment when they need to be strengthened. This reality dictates that we reconsider and reframe the challenges in the response to HIV and health, with a continued commitment to human rights while also embracing wider principles of social justice. This is not only necessary to achieve the 'Fast-Track' to ending AIDS, but will also be an important outcome of 'Fast-Track'.

The Think-Tank will create a space for urgently needed critical analysis of both achievements and failures in advancing human rights and social justice in response to HIV. The Think-Tank will act and speak with an independent voice, drawing on the different

perspectives, expertise and experiences of many working for human rights and social justice in the context of HIV and health in Eastern and Southern Africa.

Based on the findings of a recently completed rapid assessment on HIV, health and social justice, commissioned by the UNAIDS RST ESA, the Think-Tank will work to catalyse a much-needed strengthened human rights and social justice response in the region as a critical input to achieving the 'Fast-Track' targets. At the outset the Think-Tank will undertake a contextual analysis, through a uniquely African lens, to assess the key enablers and impediments to the expansion of human rights and social justice in the response to HIV in the region.

A full report of the Think-Tank meeting is available at the RST.

4.2.3. Regional treatment forum

Following the one-day consultation a half-day meeting was held to establish a Regional Treatment Forum. Thirty-two participants attended: from the UN family, US – CDC, International NGOs (MSF, CHAI, EGPAF and ASLAM), Civil Society Organizations (SAFAIDS, Youth Organization, Right to Care, EANNASO, INERELA+, PATA, AMSHeR, country representatives and academia/research.

The objectives of the meeting included:

a) Providing coordinated support to countries to fast-track implementation to meet the HLM and 90-90-90 targets towards ending AIDS by 2030.
b) Sharing strategic information including regional priorities, networking and mutual support to facilitate scale up.

c) Creation of a platform where development partners (bilateral and multilateral), regional entities (i.e. SADC, EAC and COMESA), academic and research institutions and civil society organizations (CSOs) play a critical role in supporting countries in implementation of HIV treatment services.

d) Sharing strategic information including best practices, networking and regional priorities.

The Forum noted that while the ESA region has made very good progress in treatment scale-up with an estimated 8.1 million people receiving ART by mid-2014, many challenges and gaps remain. The Forum identified a number of key issues needed to fast-track treatment towards the 90-90-90 targets, including: access, reduction of barriers, community mobilization, social barriers, and the need to scale up proven methods to reach ALL.

It recommended:

- Strengthening community engagement using a combination approach to deliver services, particularly HIV testing uptake and treatment adherence support (mass media, advocacy, various influencers, etc.

- Use of innovative service-delivery models to reach some vulnerable populations and improve services uptake

- Stock-outs of drugs remain a challenge in supporting adherence and scaling up
- Health systems remains weak to deliver quality services that leads to limited VL, stock-outs, inadequate quality of services
- The need to create a package for HIV testing that will include other services like BP, blood sugar, HBV testing to reduce stigma
- Support active referral to ensure that linkages to services are working effectively.

The Forum agreed on a set of specific actions needed to ensure it continues effectively in the achievement of its objectives.

A full report of the Treatment Forum meeting is available at the RST.

4.2.4. People with disabilities

The International Disability and Development Consortium (IDDC - a global consortium of 25 disability and development non-governmental organizations (NGOs), mainstream development NGOs and disabled people's organizations (DPOs) supporting disability and development work in more than 100 countries around the world) submitted a Draft Discussion Paper with regard to the pressing need for the better inclusion of people with disabilities in the global response to HIV and AIDS, and the new UNAIDS Strategy. The paper calls for a future UNAIDS disability strategy that is comprehensive, however, also one that sets specific aims and goals that are monitored and evaluated over time. The paper highlights ten strategic actions to be addressed:

a) **Strategy background:** to provide a comprehensive background on the intersection of disability and HIV, including HIV and disability prevalence data, evidence on the vulnerability and strength of people with disabilities, as well as evidence in regard to HIV-related disability.

b) **Goals and Objectives:** SMART, concrete objectives and goals.

c) **Benefits:** a disability strategy should clearly articulate that without including disability, UNAIDS will not be able to achieve its goals in relation to HIV.

d) **Principles:** need to make clear reference to the principles of universal design and reasonable accommodation outlined in the CRPD as well as the relevant Articles of the convention.

e) **Frameworks:** the strategy needs to mainstream disability into global UNAIDS approaches, speaking to disability frameworks (e.g. community-based rehabilitation (CBR), International Classification of Functioning, Disability and Health (ICF)).

f) **Populations:** A strategy can take cognizance of current discussions around populations and develop an approach in regards to key, vulnerable populations and disability definitions.

g) **Strategic Issues 1:** A strategic approach needs to advocate for the inclusion of persons with disabilities into all parts of HIV prevention, such as behavioural interventions, condom promotion, accessibility of information, voluntary medical male circumcision and prevention of mother-to-child transmission. The inclusion of disability in National Strategic Plans on HIV can be a marker of how well this integration has taken place on a planning level.

h) **Strategic Issues 2:** Addressing HIV-related disability is a complex issue, so a multi-disciplinary approach is needed to develop suitable and cost-effective responses to co-morbidities and disabilities associated with HIV.

i) **Implementation:** Implementation needs to use a twin-track approach: i) engage and incorporate HIV within already existing work on disability and promote disability rights legal frameworks such as the CRPD, and, ii) include disability within basic HIV program activities and all social and program enablers.

j) **Monitoring and Evaluation:** Monitoring and evaluation of this strategy will have to play a key role.

A set of specific recommendations to UNAIDS is included. The Draft Discussion Paper is available at the RST.

4.2.5. Country consultations

Not all these have been reported yet, but some commonalities have emerged.

Countries are highly aware of their **local environment:** potential political changes, such as elections; negative external influences on both domestic and external financing; specific legal environmental issues; 'neighbourhood' issues that have potential to influence cross-border migration; and, institutional strengths and weaknesses in their health systems. They are also well aware of their achievements, and gaps, and the extent to which these are reflected in national planning and strategy.

Common areas that are **prioritised** are the integration and education on sexual and reproductive health rights targeting adolescents; the need to increase the coverage and uptake of ART, PMTCT and SMC; the importance of improving the generation and utilization of strategic information to facilitate decision making; the need to improve resource utilization, to identify efficiency barriers, and to improve technical efficiency.

Key '**game-changers'** identified are strengthening interventions targeting adolescents to reduce their vulnerability to HIV; intensifying evidence-based interventions for key and vulnerable populations including women and girls; scaling up treatment quality and monitoring; and shifting towards geographical targeting of epidemic hotspots to reverse the spread of the virus.

Key areas for **UNAIDS' support** include: technical support to the national partners for rights-based and gender-sensitive HIV programming; mobilizing political support and civil society voices around the HIV response to improve accountability; support for the generation of disaggregated and decentralized strategic information; promoting and sharing global and

local innovations; and advocating for the prudent use of resources based on the principles of the investment approach and efficiency maximization.

Country reports are available at the RST.

4.3. Issues papers

To inform the one-day Consultation managed by the RST (see next section) a series of simple issues papers were prepared, largely by RST staff. These were not official technical papers, but were short highlights (1-3 pages only) of seven key themes identified by the RST as a useful framework within which to answer the five questions. These themes were used to form groups for discussion of the five questions in the one-day Consultation (see below).

The seven themes were:

- **Prevention** with a focus on key populations, populations left behind, sexual transmission, girls and young women, and youth
- HIV **Treatment and EMTCT**: the integrated response
- **Human rights and social justice**: Participation and equity
- **Gender**: Equality and gender-based violence
- **Community level engagement** in service delivery: demand, supply and accountability
- **Political commitment**: the hard choices
- **Sustainability**: efficiency, innovation and integration

The papers were very loosely structured around the five questions.

They were distributed during the one-day Consultation and used primarily by the Technical Discussants to help focus discussions in the groups. It was noted that they were being referred to by many participants during the discussions.

The papers have also been used to inform some of the background material in this report.

4.4. The UNAIDS Strategy 2016-21: Fast-track, consultation, regional specificity

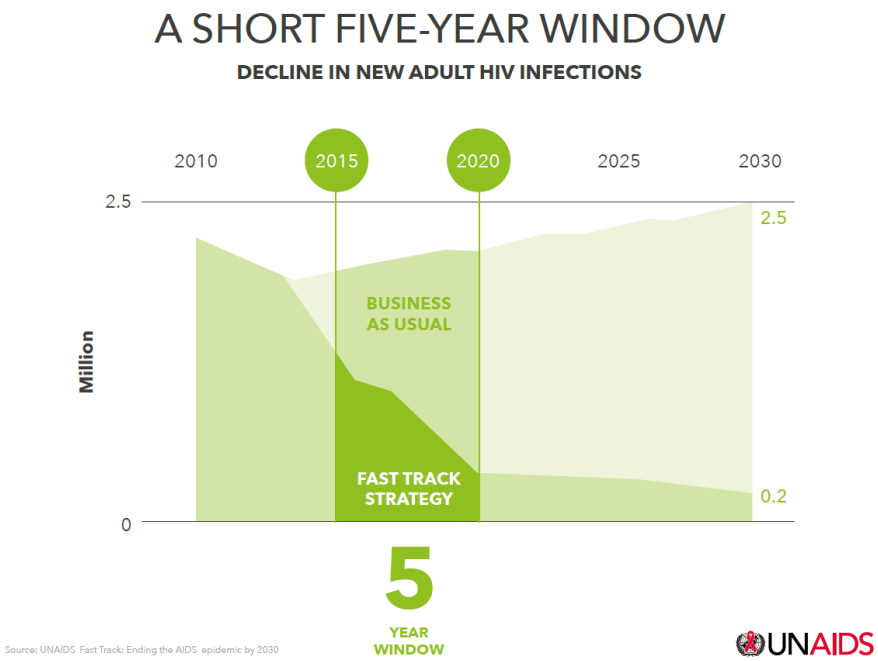
In 2010, UNAIDS Board endorsed a vision for the future of the response. The vision of zero new HIV infections, zero discrimination, zero AIDS-related deaths, quickly captured the imagination of global leaders, national AIDS councils, community NGOs and activist networks at all levels. While the vision of the Three Zeros is aspirational, the journey towards its attainment was set out through a series of concrete milestones for 2015 in the UNAIDS 2011-2015 Strategy: 'Getting to Zero'. Significant progress has been achieved in meeting these milestones.

As a result, the global AIDS response can be ended as a global threat by 2030. HIV treatment can dramatically extend the lifespan of people living with HIV and effectively prevent HIV transmission. Many proven opportunities for HIV prevention beyond medicines, including condom programming, behaviour change, voluntary medical male circumcision and

programmes to empower key populations to reduce HIV risk are available and work. HIV programmes are further dramatically strengthened when they are combined with social and structural approaches.

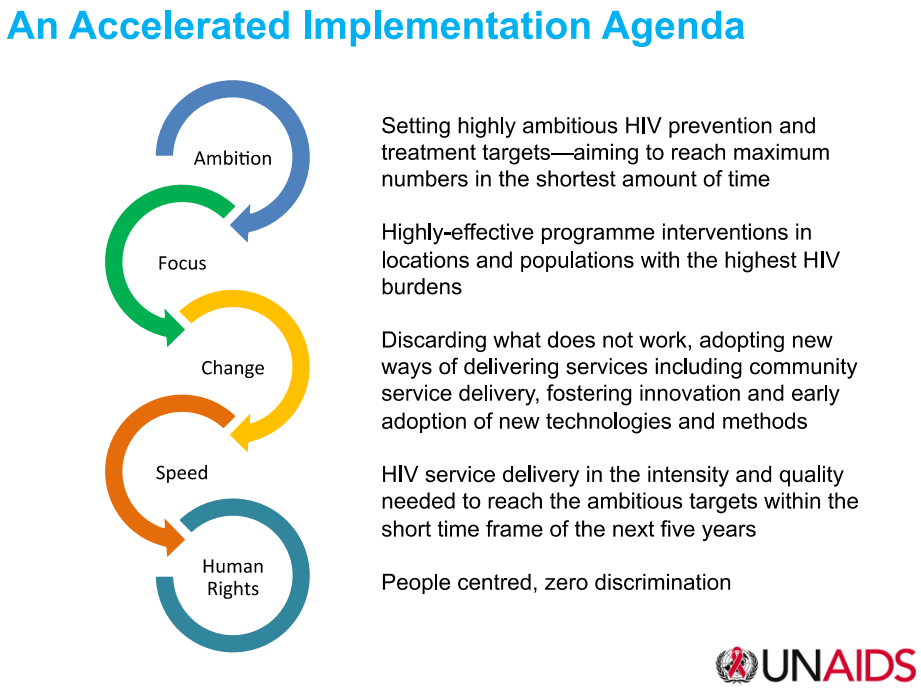
But to reach the targets for 2020, and end AIDS by 2030, countries and their partners need to significantly increase investments, programmes and policy change, and focus on populations, locations, and innovation.

There is a short window of opportunity, between 2015 and 2020, when, with the Fast-Track strategy, great progress towards the global UNAIDS goals of zero new infections, zero deaths and zero stigma and discrimination can be achieved. If this window of opportunity is not seized, however, there is a real risk that new infections and deaths will start to rise again, leading to a far worse epidemic than we know now.



For sub-Saharan Africa, reducing the HIV burden has been found feasible by applying a set of highly ambitious targets. Sub-Saharan Africa would reduce by about 90% their new HIV infections and by 80% the AIDS-related deaths. Sub-Saharan Africa would contribute to a 72% of the global reduction in new HIV infections. The East and Southern Africa Region has its own special role to play in achieving these targets.

UNAIDS call this An Accelerated Implementation Agenda. It involves Ambition, Focus, Change, Speed and Human Rights.



To achieve this Accelerated Implementation Agenda, globally, regionally and nationally, the UNAIDS Board has called for an updated strategy. The Board has reaffirmed the UNAIDS vision of the Three Zeros and the strategic directions in the current UNAIDS 2011-2015 Strategy, and has requested UNAIDS to undertake a multi-stakeholder consultative process to update and extend the UNAIDS 2011-2015 Strategy through the fast-track period 2016-2021, while taking into account the 2011 Political Declaration on HIV and AIDS and the ongoing discussions on the post-2015 Sustainable Development Goals; and report back on this process at the 36th PCB. The Board has asked UNAIDS to present this updated Strategy and UBRAF, for decision at the 37th Programme Coordinating Board meeting.

This strategy will not be entirely new. It will retain the 3 zeros, the 3 Strategic Directions, and the existing goal and target architecture. It will continue to serve as a visionary and bold roadmap for the global AIDS response and the UN Joint Programme. It will, however, be updated to account for commitment to ending AIDS, evidence from the **Gap Report** on who is left behind, the necessity and urgency to Fast-Track the response; and the changing global context-–for example:

- Growing inequality
- Majority of poor and people living with HIV now in middle-income countries
- Situation of ‘fragile’ states
- Urbanization and need to engage cities
- Demographic boom
- Expanding global health agenda, etc.
- The SDGs.

It is expected that the updated Strategy will focus on five cross-cutting themes, or impact areas:

a) **Information**: “Going granular”, using local, disaggregated data to identify priorities; empowering local decision-makers and communities to generate and apply strategic information; with rigorous monitoring of integration and social and political determinants.

b) **Innovation**: with delivery systems transformed through strengthened communities and mobile technology; with a youth-led movement for prevention, and healthier social norms; and, with global public goods for health financed and available.

c) **Integration:** Using decentralized, integrated services for TB, SRHR, hepatitis, cervical cancer, etc.; using strengthened HIV-sensitive social protection; and, with joint action to address common determinants of social justice issues.

d) **Investment**: Front-loading investments through diversified (international, domestic, innovative) sustainability plans; and, increased investment in integration, prevention, and civil society.

e) **Inclusion**: with people living with and affected by HIV engaged in all aspects of the response; and, with deliberate and explicit empowerment of populations currently left behind, and with individuals and groups who face the greatest barriers to participation to access relevant services, demand their human rights, and enact change.

The UNAIDS Board has also explicitly asked for regional emphasis and specificity in the updated Strategy, with clarification of regional epidemic patterns and responses, and clear identification of regional priorities and regional ‘game changers’.

There is now recognition that there is no “global” epidemic, but rather a number of regional and local epidemics. While global goals are good for advocacy, regional priorities provide stronger ownership. Regional political bodies can promote mutual accountability; a regional strategy promotes regional cooperation on issues requiring collective action (e.g., migration); and, can lead to greater efficiencies and cost savings (e.g., potential for regional procurement).

As a result, over the course of 2014, all seven UNAIDS regions have completed regional consultations on country and regional target-setting. These consultations have primarily focused on setting HIV treatment targets for beyond 2015; but also included other AIDS response targets. From these consultations, guided by evidence, modelling and implementation science, a clear call for the Fast-Track targets emerged.

During the One-day Consultation, UNAIDS staff from HQ presented their perspective on the Fast-Track targets and the development of the UNAIDS Strategy for 2016-2021.

4.5. The one-day consultation in Johannesburg on 23 March

On 23 March, a one-day Consultation was held in Johannesburg, South Africa, organised by the RST-ESA (programme included in Annex 1). One hundred and seventeen delegates participated: from countries; civil society organisations--regional, national and community-

based; academia; RECs; and, UN family members from countries, the region and HQ (Geneva). Four Ministers from the region attended. See Annex 2 for the list of participants.

The Consultation was structured to present the context, both with respect to the HIV epidemic and response in the region and the global UNAIDS strategy development; and, to focus on regional perspectives and input. Participants worked in 7 groups to answer the five questions with specific focus on each theme. Plenary sessions at each stage of the program allowed general discussion and direction setting.

The output was primarily answers to the 5 questions of the UNAIDS Discussion Paper, with respect to the seven themes identified as key issues for the region (see 3.3 above). This is presented in the next section of this report.

In addition, a **High-Level Ministerial Group** deliberated through the day, presented its own report, and responded to the participants in a final Ministerial Panel.

Key issues that both plenary and group work sessions addressed were:

- The context of the epidemic in the region
- The window of opportunity for the Fast-Track response
- The need for a common regional approach/strategy to grasp this window of opportunity
- The strategic priorities and 'game changers' needed for a Fast-Track response
- The high level political commitment required, and offered, and,
- The key role of UNAIDS RST in providing a platform for continuing the consultation.

A detailed report of the one-day Consultation is in the next section.

4.6. The partnership platform

Dr Pierre Somse, Deputy Executive Director of the UNAIDS RST-ESA presented the rationale behind, and plans for a proposed renewed regional partnership platform to ensure that these region-wide, participatory consultations go forward.

He noted that to succeed in ending AIDS by 2030, all partners in the region must work together. Only together can this burden be lifted. There has been a vibrant partnership in the last decade; but today is a new departure on this public health threat, and all partners must work more efficiently and effectively in a systematic and structured manner.

To achieve this, and to re-establish the Partnership, a draft concept note has been prepared and shared.

- The **vision** is to fast-track the HIV response to end AIDS by 2030.

- The **value** is the need to discuss and align our strategic priorities; to link different constituencies; to develop and align advocacy messages; to collect, translate and disseminate important HIV-related knowledge and best practices; to ensure institutional links between the HIV community and the broader activities of national governments, development partners and non-state actors; to enable partners to

achieve more together than they would have been able to achieve individually; and, to promote accountability for resources and results.

- The **membership** will be primarily regionally focused organisations.
- The **next steps** include: establishing a constituency-based Task Force to formulate the terms of reference for the Regional Partnership platform, which will be shared for inputs. There will be nominations of constituency-based representatives to the Committee. And, the plan is for the extended Partnership to meet annually.

The Swedish International Development Cooperation Agency (Sida) has approached UNAIDS to make their support more efficient, and Professor Sheila Tlou also is working on this initiative with the private sector. UNAIDS also plans to invite municipality representatives from the Alliance of Mayors to the forum.

Dr Somse opened the floor for any comments, and the following were the responses:

- "It is important to include Ministers in the partnership as they represent all our ministries."
- "Are we going to have a regional strategy or just feed into the global strategy?"
- "We need to have an analysis of other partnerships and why some didn't work and whether the development of this partnership platform is a resource-efficient strategy.

Dr Somse responded that the Partnership would respond to what the needs are; it is essential to have a partnership that works, through re-engineering and making it more effective. The region needs its own strategy. UNAIDS has already planned to work with partners to customise a strategy for the region. The partnership will monitor the strategy response and mobilise for its implementation. Regional and country leadership are critical.

5. Consolidated thematic report from the one-day consultation

This section reports the results of the group discussion work among the participants at the One-day Consultation, in response to UNAIDS' five questions, and the seven thematic areas identifies for the region. The group reports have been consolidated according to the 5 questions; in addition, discussions from the plenary have been consolidated into these questions, too.

The report from the **High Level Ministerial Group** and the final **Ministerial Panel** discussion are included at the end.

5.1 Key issues raised in plenary

A number of key issues were raised in the various plenary discussions; these were also echoed in the group discussions. These are given here, with illustrative quotes from many respondents.

- The vital importance of **young people**, the epidemic among young people, and the need to find 'game-changing' responses: 50% of the deaths from AIDS in the region are now in adolescents *is new*. The increasing number of infections in youth highlights the critical importance of comprehensive sexual and reproductive health education. My great plea is to involve youth in programming and making progress as they need to be involved; we need to focus on new infections—what is driving the new infections in youth.

- The need to address **deep-seated, underlying social and cultural norms, standards and custom**s, among which **gender** is key: Prevention is complex. We need to get away from the 'game changer' as a 'magic bullet' approach. We need to focus on the root cause of a problem to have an impact on it. We definitely are at the crossroads regarding criminalisation of HIV and same-sex barriers. We need to change society and the legal barriers. We need to include LGBTI group members and sex workers in the strategy. In the Gender and Gender-Based Violence Group we discussed that re-socialising men and boys is dismissed because it is too difficult. But until we challenge gender norms, we're not working at the community level. We need to change gender norms in our families. The UNAIDS focus is similar to PEPFAR's approach, but we cannot reach a tipping point without a greater investment in social mobilisation. Prevention is being lost amidst the biomedical approach; we need structural and behavioural approaches, too!

- The importance of **ownership** of the HIV response, by implementers, politicians, traditional and modern leaders, the private sector, and communities: We need to change the ownership of the epidemic: we have a history of post-colonial rhetoric, but we are struggling with implementation and political will. Western donors are reducing funding, and we have to invest more in health. We still behave like a teenager, with the West taking responsibility, such as what happened with the Ebola epidemic. We've tended to give away leadership to Geneva and Washington. We have to set local agendas nationally, and if Washington and Geneva can assist us, great. Leadership is pivotal for the way forward—from the top to communities and key populations. For sustainable financing we need to consider a country like a construction site, with a certain percentage of the funding going to health—from 5 to 8%; but, we also need to track where it's going, and we need to integrate HIV, gender, and human rights and in the same way environmental impact assessments are conducted. We need to build the sustainability elements into the core business of businesses. In the Sustainability Group we said that corporations should report on health metrics (indicators) and the impact on their bottom lines. How can we unlock the funds budgeted for health, such as those in the private sector and those not available through maladministration? We need to be tweeting messages of encouragement, but also have 'take-home' messages: HIV is not over. We need a new societal and energized political revolution to end the epidemic by 2030. Another game-changer is when leaders own up to being HIV-positive or when they may have a different sexual orientation.

- The key role **civil society and communities** have to play in an effective response to the epidemic, both with regard to prevention and treatment and advocacy and accountability--and the vital **role UNAIDS** has to support this: Civil society is still an outsider, but we need to be at the centre of the epidemic. Community responses are

essential for zero discrimination. The Community Group emphasised some things that are not being addressed—community groups are dying! We need technical support and advocacy support from UNAIDS and we need to sustain that support and funding. We also need resource mapping. We're just running to respond to RFPs. Civil society needs help from UNAIDS to negotiate funding. Small community-based organisations (CBOs) cannot put together good proposals as the proposals get more and more complex. CSOs are mostly mediators between communities and donors, which is difficult. UNAIDS should provide support to CSOs, especially on advocacy. UNAIDS should reconsider community-level funding. On HIV treatment: our forefathers advocated for treatment and that is why some young people are on treatment. We need youth-led community groups. Can UNAIDS support this? It would be a game changer.

- The **dramatic expansion of treatment** has changed how we think of the epidemic: HIV does not kill! I have lived with HIV for years with my ART – the idea of dying from AIDS doesn't occur to me! Young girls nowadays are more scared of becoming pregnant than of HIV. The young people under 15 today know nothing of AIDS. But…all the focus and attention and money is for treatment-–prevention is getting left behind. How do we reach those who don't access health services-–the poor, rural women, the disabled, people kept away by stigma and discrimination?

5.2. Consolidated answers to the 5 questions

a) How will developments – globally and in the region – impact the epidemic and response in the region, in countries and at the sub-national level over the next six years?

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

- **The post 2015 SDGs**, although not yet finalized, present a new context for the AIDS response **as AIDS is not a stand-alone goal.** The SDGs are a call for action that we cannot work in isolation. They provide the opportunity for building on the unique lessons learned from the extraordinary AIDS response; and, for building synergies with broader programmes, in particular reproductive health, gender, and universal health coverage.

- **Flat-lined international resources, competing development priorities, and new priorities for development investment** pose a challenge for the sustainability of AIDS investments and preserving the gains made.

- **Some countries in the region are graduating to high-middle and middle income level**, limiting their access to international resources - while this economic label can hide important inequalities in terms of poverty, development, and rights.

- **Health and community systems are not at the same performance level in all countries, and particularly weak in the fragile st**ates, where the AIDS response challenges are compounded by security issues and humanitarian crises. The Ebola crisis to our west has shown how vitally important health and community systems

and governance are, and the critical role of the trust people have in their governments.

In their detailed discussions, the participants enlarged on further critical changes that have taken place in the region.

The biggest contextual change in the region is the expansion of ART, with 8.1 million people on treatment and 78% PMTCT coverage. This is having an impact in many ways: health services have been challenged and in many ways transformed by the demands of treatment. Quite apart from sheer burden of demand and numbers, diagnostic and treatment innovations, task-shifting and simplified regimens, a more holistic approach to patients, M-health and communications technology, and increasing integration of services are becoming more common and increasing access to services. A variety of new service delivery approaches are having to be developed: for adolescents living with HIV, both in and out of school, for paediatric cases, requiring household level support, and for community services and support groups as ART gets closer to communities. These challenges and changes will continue with the need to improve retention and adherence, and to ensure people maintain an undetectable viral load. The spread of treatment is impacting and will continue to impact on prevention: people will be less infectious; there will be lower transmission rates.

Of particular importance and concern for the region, however, is that while new infections have gone down in all countries, the face of HIV has changed - it is now predominantly a young woman—and adolescents: 50% of the deaths from AIDS are among adolescents. In 2013, HIV incidence across countries in the region was high among women in their late teens and early 20s. This equated to 4300 new HIV infections among young women aged 15-24 years per week among 14 ESA countries. This means we must still focus on prevention; but we must target prevention programmes where they are most needed: we must provide comprehensive sexuality education that will equip young people to make good choices: “young people who are teenagers today do not know that AIDS kills: today it is a question of choice”. We must address the under-lying social and cultural norms that pre-determine gender roles, support gender inequality, and undermine prevention.

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

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

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

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

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

In the long term, climate change, mobility and food security all present challenges to health in the region.

b) What achievements of the regional response should be expanded and built upon? Where are the main challenges and gaps? Who is being left behind and why?

A number of prevention programmes have been successful in some areas: community engagement ("We have killed off stigma and discrimination, which has allowed more access"); changing sexual behaviours (reducing multiple concurrent partners, delaying sexual debut); male circumcision, particularly among younger men; peer education ("The central role of peers in how individuals respond cannot be overstated"); condom distribution ("condoms work"); engaging governments, parliamentarians, etc.; multi-sectorial approaches ("We can't stop with the AIDS service providers; we must also reach police officers, judges, those who work in drug control"). But much better evidence of just how these prevention programmes work, and what aspects work best, is required. We need to ask what prevention programmes have not been successful, and do less of such activities; and what works well, and do more. "

Many people including key populations, adolescents and communities in remote and hard-to-reach areas are being left behind: internal mobile populations, young people not in school, young people at 'hot-spots' of highly risky behaviour, girls and young women at risk of sexual abuse and violence, MSM, TG and sex workers, traditional leaders as role models, workers in the informal economy, persons with disabilities. Prevention programmes need to become more focused, and more targeted at these groups; we

need not only to design programmes that will reach these groups, but also ensure that they are attractive and acceptable to these group--“We have to get people to want to use them and to keep using them; we have to spend more time in that murky space”.

HIV testing remains low despite rapid scale-up--only 45% of people living with HIV know their HIV status and only 10% of young men and 15% of young women (15–24 years) were aware of their HIV status in 2013.

Only 41% of all PLHIV in the ESA region were on treatment at the end of 2013, with significant variation in coverage among countries and within countries. People are being left behind in the roll-out of treatment: people with disabilities, those living in remote areas (such as fishing sites), refugees and IDPs who afraid to access services, adolescents in boarding schools, prisoners and women who do not normally access health services, even for delivery. Services must be expanded and extended to reach all these people. In addition, with increasing access to services, quality of service delivery needs to be maintained – this can be costly and challenging.

The great growth and empowering of civil society and community level engagement is a vital area to build on and take forward. “A few years back when the health system could not cope, it was community systems that responded; communities provided care when it was needed when the biomedical side was overwhelmed; community structures of various kinds played a big role.” These need to be built upon to support issues of adherence, stigma, demand creation, advocacy, engagement and accountability. In addition, community-driven prevention regarding cultural norms and practices is something that can be done effectively through community-level engagement and by the civil society.

Key drivers of the epidemic for women and girls are grounded in cultural norms and practices, are multi-layered and mutually reinforcing--but also preventable: these drivers include the unequal relations between women and men, and socio-cultural norms and practices. Gender thus remains a major issue increasingly visible and recognized; though still highly neglected. The lack of awareness, visibility and commitment to gender equality, harmful gender norms, women’s and girl’s agency and empowerment, sexuality, and the elimination of gender-based violence was highlighted. While there has been some progress with gender-responsive policies and legislation, political commitment, strategic information, and economic empowerment programmes (such as social protection, cash transfers, livelihood interventions), all these need to be substantially built on and strengthened. Adolescents and young women and girls, particularly girls not in school, are especially neglected.

There is increased understanding and evidence of structural drivers and the role of human rights, social justice, participation and equity in responses to HIV in the region. Some levels of increased commitment and integration of this can be seen in national, regional and global strategies, policies, plans, programmes and interventions; and some successes in improving human rights, social justice, participation and equity. There remain, however, significant gaps in the evidence, understanding, inclusion and prioritisation of specific populations (e.g., MSM, transgender populations, sex workers, people who use drugs, adolescents and children, women, people with disabilities, migrants and refugees).

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

c) In order to reach the Fast-Track targets, what should be the region's strategic priorities in the response?

The Consultation participants stressed the need to strengthen coordination, sustainability, targeting and focus, the evidence-base, implementation, efficiency and energy of prevention programming. Key priorities are:

- **Addressing the needs of adolescents and young women and girls**. Re-energizing the prevention focus for these groups, redirecting resources for them, revamping political commitment to them, and overall re-socialising of men, women, boys and girls is a fundamental key to prevention in the region.

- **For treatment the most important thing is to strengthen the health systems t**o build upon the scale-up of treatment that has occurred. Laboratory capacity, point of care diagnostics, service integration (HIV/TB, SRH, MNCH), task-shifting and community involvement all need to be strengthened, along with human resources, procurement and supply chain management, data management and evaluation and use of dashboards and integrated palliative care. A drastic focus on children is necessary with coverage at only 27% in the region.

- **Continuing to build evidence across the board.** Increasingly accurate identification of key populations; of what works and what doesn't; pushing for concrete implementation and action based on evidence and focusing efforts on those issues that have been shown to work (e.g., social protection, law review, improved law enforcement). Countries need to strengthen the generation and use of evidence on efficiency to inform resource allocation and strategic policy shifts; and, strengthen the tracking of and accountability for resources.

- **Increased political commitment and leadership on the "hard issues**" is needed: addressing the 'critical enablers', such as human rights, the legal environment, and the chain of accountability. Countries need to promote better harmonisation of laws and legal frameworks, policies, strategies and budgets to address sub-regional and cross-border issues. Some countries which are key to meeting the region's Fast-Track goals also fall within the category of countries with newly discovered mineral wealth; working with the private sector in the extractives industry in countries has the potential to reap multiple benefits.

- **We need a new commitment to change, which does not require financial investment, to address socio-cultural issues, norms and practices with regard to young people and women.** Given the role that cultural and community leadership (e.g., chiefs) have the potential to play, in both advocating against harmful cultural practices, including cultural norms and adherence to laws which outlaw these practices, there is potential to also partner with this category of leaders. The African Queens and Women Cultural Leaders Network (AQWCLN) is one key network; male cultural leaders are also important actors in enforcing understanding of permissible

cultural norms and practices. For example, in Malawi, the traditional leaders advocated for raising the legal age of marriage in Malawi from 15 to 21 years of age, and many have established laws in their own districts setting the minimum marriage age for a woman at 21.

- **Addressing the needs of key populations,** such as MSM, transgender populations, sex workers, people who use drugs, adolescents and children, women, people with disabilities, migrants and refugees is essential. A prioritized strategic approach needs to advocate for the explicit inclusion of key populations into all parts of HIV prevention: behavioural interventions, condom promotion, accessibility of information, voluntary medical male circumcision and prevention of mother-to-child transmission.

- **A number of opportunities to address sustainability issues were identified.** The SADC Action Framework on Sustainability and the ongoing EAC Sustainability analysis present an opportunity for the region to increase the focus on sustainability; the increased focus on efficiency and cost-benefit analysis has captured private sector interest, increasing their willingness to finance health programmes; country level mobilisation of the private sector using available national business coalitions; regional initiatives to promote drug pooling/pooled procurement; work ongoing in 16 countries to mainstream and integrate HIV, health and gender in capital development, which should be harnessed to improve health financing; the existence of regional initiatives--The SADC Trust Fund, SADC HIV/TB initiative, etc. These will need to be carefully coordinated to minimize duplication of effort

d) What will need to change in support of those priorities? What are the "game-changers" – in terms of policy and law reform, funding, resource allocation, partnerships, service delivery, empowering civil society, science and innovation, and links with other health and development efforts?

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

- **Reinvigorating prevention**: Success or failure in preventing sexual transmission in the region is the defining factor towards the vision of zero new HIV infections. Prevention of sexual transmission must be revitalised and focused where new infections are taking place. We need both specific prevention programmes (e.g., comprehensive sexuality education, condom distribution, etc.) and broader programmes that address the drivers and underlying norm--to 're-socialise' boys and young men, empower girls and young women, and recalibrate the mind-sets of adults and leaders.

- **Investing in young people, with a particular focus on young women and girls** is vitally important. A number of new initiatives have started-–"All In", recently launched under the leadership of UNICEF, will expedite the response for adolescents in the ESA countries; PEPFAR launched in December 2014 the "Dreams" initiative to accelerate implementation of programmes for young women and girls several

countries of the region. Comprehensive sexuality education is gathering momentum; this will help address structural factors at the community level to reduce gender-based violence, ensure gender equality and build resilient, educated and independent young women. Young men must not be forgotten: prevalence among young men rises at about the same rate as among young women, but approximately 5 years later. Countries are investing resources in voluntary medical male circumcision; however, uptake and demand remains low, with only five million men/boys circumcised thus far against a target of 21 million by 2015. Key populations – sex workers, gay people and men who have sex with men, injecting drug users, migrants and others left behind remain a sensitive topic, and much more must be done to ensure access to health and social services for these groups. We have to make the commitment of states to equality and universal access to services a reality for these populations, pragmatically managing the social, cultural, economic and legal obstacles.

- **Urbanization is an evolving phenomenon in ESA countries that brings development and vulnerabilities**. Cities in many countries are not only disproportionally affected by the HIV epidemic but often have large informal settlement areas in which HIV prevalence is often high with heightened vulnerabilities. It is imperative that partnerships are established with local government and civil society and the institutional structures of cities to identify and implement a locally designed response in the high-burden cities.

- **Effective and efficient service delivery is at the core of successful implementation.** To reach the 90/90/90 treatment targets, the number of people receiving treatment will have to roughly double, the number getting tested must double, and people must have access and stay on treatment. Strengthening all aspects of health systems is needed: working for integration and greater efficiency in service delivery, getting better, localised allocation of resources, building greater community linkages and participation will all be critical.

- **Political commitment at all levels and resources** is **essential to expand the necessary new models of local responses and community service delivery for prevention, testing and treatment being rolled out in some countries.** Leadership, both central and local, both traditional and institutional, must be mobilised and sustained. Communities must be mobilised to ensure the quality of services and to hold service delivery accountable.

- **Sustainability, partnership and shared accountability of the AIDS response are essential**. Overall, the financing needs of the HIV response will remain substantial for many years to come, with current commitments becoming increasingly out of line with future fiscal liabilities. To live up to these needs and achieve the goal of sustainable response, we need to follow two paths: be more effective with available resources and develop innovative financing mechanisms: such as the new initiative between SADC Ministers of Health and the private sector in establishing a Health Trust Fund.

- **Partnership to articulate, address and resolve the needs of our region is essential.** Partnerships need to be strengthened and expanded, and effective platforms for sustaining them put in place.

e) What are the most critical ways in which the UNAIDS Joint Programme can support efforts in the region to end AIDS as a public health threat by 2030?

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

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

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

UNAIDS should use its convening role to bring together the diverse partners and use the credibility of the UN/UNAIDS to influence political leaders. Leaders can time their advocacy to before or after elections.

5.3. The High-level ministerial group and panel

The High-Level Ministerial Group deliberated through the day to determine a 'high-level political agenda' which was presented to the Plenary.

5.3.1. The High-level Political Agenda

We have to recognise key populations and work through the structures that bring services closer to these populations. We need to develop formal contracts with civil society organisations to implement programmes, which governments should fund.

- **Focus on local-level HIV epidemic dynamics:** For example, East Africa and Lake Victoria have similar problems of HIV infection among the fishing communities. The Southern African Development Community (SADC) and the Intergovernmental Authority on Development (IGAD) should bring these common cross-border issues to the ministers as a joint agenda: "Let's have one common and formalised agenda" for all the cross-border issues (truck drivers), zooming in on the specific communities."

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

- **Lead by example:** Use our high political leadership to bring in other sectors, including justice, education, and other sectors and integrate the messages into political/budgetary speeches, which can become policies.

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

- **Focus on task-shifting and investment in community workers:** to bring the services closer to communities.

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

- **UNAIDS convening role:** UNAIDS should use its convening role to bring together the diverse partners and use the credibility of the UN/UNAIDS to influence political leaders. Leaders can time their advocacy to before or after elections.

- **Evidence, 'Best Practice' and innovation:** UNAIDS should inform us about evidence-based interventions, what works and doesn't work, and high-impact interventions, so we know where to put the money to get the highest impact. UNAIDS should share results through 'one-pager' and share flexible reporting tools to identify and capture the programmatic gaps, as well as innovative interventions at the community level to reach the leaders on various levels.

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

5.3.2. The Ministerial Panel

At the end of the meeting the Ministerial Panel, comprising the three Ministers, representatives from key populations, PLHIV, Youth and the Executive Director of the UNAIDS RST, delivered key messages to the consultation.

- **He-Jin Kim - Regional LGBTI Programme Officer Aids and Rights Alliance Southern Africa (ARASA): "**The voice of key populations is the most important thing in the strategy. We are missing evidence and interventions that happen on the ground. The key populations organisations are struggling and need to be linked to other organisations and human rights and need to be at the centre of the response and the social needs must be addressed."

- **Tikhala Itaye - Vice President AfriYAN, Namibia**: “Youth and adolescents need to be at the forefront, and UNAIDS needs to put pressure on governments. You can’t do anything for youth without youth.”

- **Kenly Sikwese - Coordinator AFROCAB; NGO Delegate to the PCB:** “This is following the PCB meeting and it is owned by civil society. It is an ongoing process with the right populations and in the right locations. This fast-tracking process should not let UNAIDS run away with it, and UNAIDS does need to coordinate it. Michel Sidibé committed the UNAIDS support for CSOs to grow from 1% to 3%.”

- **Dorothy Onyango – WOFAK:** “The Pan-African Women Living with HIV have committed African women to the 90/90/90 targets and to work in partnership. We hope other countries will follow Kenya’s lead and support women living with HIV. The leadership group said very clearly what needs to be done—you have our support and we’re often told we don’t have the capacity”.

- **Dr. Dirk H. Mueller - DFID**: “This has been an incredibly rich discussion. It has been both targets- and evidence-based. The big discussion has been about domestic financing and owning the response and gearing it to the local epidemic. This needs to be linked to governance and accountability and include these and make a strong economic case/business case on what works to show the worldwide community the scope for investing more resources.”

- **Hon. Sibongile Ndlela-Simelane - Minister of Health, Swaziland**: “We’re ready as the Ministry of Health to push the ‘fast-track’ and put the Ministry of Finance on board for financing and invite them to the next [regional] meeting to increase funding. As well as political champions, we need to look at putting the traditional leaders on board and the custodians of culture and religion. They will be around in 2030, after our five-year terms are up!”

- **Mr James Macharia - Cabinet Secretary, Ministry of Health, Kenya**: “Thank you to UNAIDS for arranging this critical meeting and I feel enriched by this meeting. This is a very diverse group here, and we need diversity to win the battle against HIV. The Ministries of Health cannot do the job alone. We need the Ministry of Energy, the Ministry of Finance, the Ministry of Gender, and all the ministries, and not just the Ministers themselves, we need the highest level—the head of state. Only four weeks ago, we had the launch of the “All In” Global Campaign in Nairobi, including Parliament and the judiciary. Dr. Luis Loures and Professor Sheila Tlou from UNAIDS were there. We agreed today that we need specific milestones and these factors: 1. Advocacy—there is a meeting in Nairobi by the First Ladies coming in July, and they can provide the emotional aspects of HIV. 2. Leadership. 3. Finance—there is donor fatigue, and the Global Fund and PEPFAR will not keep throwing money at us. We need to start digging deeper ourselves. 4. Civil society organisations are not having enough of a chance to interact with ministers. In Kenya the Total War against AIDS (TOWA), funded by the World Bank, had more than 500 CSOs involved, and it was very successful.”

- **Professor Sheila Tlou - Executive Director, UNAIDS RST-ESA**: “In Eastern and Southern Africa we now have a product-–the results of this consultation and it will

feed into the global strategy. But more important, we now have our own product, which we know we can run with, and the Task Force to implement it. We promise at UNAIDS to implement it. We will continue to provide evidence first and foremost. We will continue to convene and discuss best practices, but we need to document them even though we have the most of any region. We will convene for capacity building. We will have a workshop for CSOs to write abstracts focusing on the World AIDS Conference in Durban so they can shine. We need to show that HIV still poses a problem. We need to ensure that we advocate with each and every person: traditional leaders, communities, civil society, donors, etc. We will do resource mobilization with the Global Fund and domestic financing in countries—there has been progress since 2010! And, we promise to be innovative, not just thinking outside, but even throwing away, the box, and then deciding where to put it, such as the SADC Trust Fund."

6. Key messages and way forward

The consultation was welcomed by participants and the opportunity to make input to the UNAIDS Strategy 2016-2021 was appreciated. The discussions were robust, thoughtful and direct. The region has a clear view of its priorities, and the directions it needs to go. There was a depth of experience from different perspectives of the HIV epidemic, that currently characterizes the region: it knows its epidemic, knows what drives it, has lived and worked with it for decades and knows what works, doesn't expect any 'quick fixes', but is also quick to recognize changes in situation, circumstance and epidemiological reality, and respond to them. There is a strong sense that the region will emerge better at the end of AIDS.

6.1. Key messages from the consultation process

A number of key messages arose from the consultation:

- The expansion of treatment has transformed how the epidemic manifests, is perceived and is responded to in the region.
- Curbing sexual transmission among young people, particularly girls and young women, is vital: without this the epidemic will remain.
- A comprehensive approach to sexuality education, along with longer-term approaches to address harmful cultural norms and underlying gender inequalities, are essential to empower young people to identify, sustain and expand effective responses to HIV.
- Key populations remain under-served, under-involved and under-represented**;** risks are exacerbated by stigma and discrimination**.**
- Communities and civil society have had, and will continue to have, key roles in expanding and sustaining prevention, treatment, empowerment and accountability and must be supported.
- Political commitment for the hard choices and for sustainability remains essential; innovative ways must be identified to sustain political commitment.

6.2. Way forward

A clear demand emerged from the consultation, for a specific ESA Regional Strategy; not just some regional specificity within a global UNAIDS' strategy, but rather a specific strategy derived from regional realities, based on a broad regional consensus, owned by the region, driven by the region, and to which all partners in the region can be held accountable.

A number of steps can be taken immediately towards the development of this strategy:

a) Circulation and validation of this consultation report.
b) Establishment of a Task Force to revive the Partnership Platform.
c) Convening, using this platform, of a Task Force to develop a Regional Strategy.

7. Appendices

Annex 1: Participants of the one-day consultation

Eastern and Southern Africa Regional Multi-Stakeholder Consultation on UNAIDS Strategy 2016 - 2021 23 March 2015 Johannesburg, South Africa			
List of participants			
Country	**Name**	**Position**	**Institution / Organization**
Angola	António Coelho	Executive Secretary	ANASO Angola
Botswana	Makhamokha Mohale	Executive Secretary	Champions for an AIDS-Free Generation
Botswana	Mr. Tshepho Mophuting	Programme Planning Manager	NACA Botswana
Botswana	Mr. Anders Pedersen	Resident Representative and UN Resident Coordinator	UNDP
Ethiopia	Emmanuel Etim	Pan African Coordinator	Africa Civil Society Health Partnership Forum
Ethiopia	Tinos Kebede	Program Manager	National Network of Positive women in Ethiopia
Ethiopia	Dr. Tsehaynesh Messele	Chief Executive Officer	ASLM
Ethiopia	Amitrajit Saha	Senior Advisor HIV and Human Rights	UNDP
Ethiopia	Tilly Sellers	HIV, Health and Development Team Leader	UNDP
Kenya	Sylvie Bertrand	Regional Advisor, HIV/AIDS	UNODC
Kenya	Anne Ireri		KELIN
Kenya	Wanjiku Kamau	Regional Representative	International AIDS Alliance
Kenya	Mr. James Macharia	Cabinet Secretary	Ministry of Health
Kenya	Irene Njoki Mirithu		Ministry of Health
Kenya	Dorothy Onyango		PAPWC
Kenya	Violet Shivutse	Global Civil Society Advisory Group Member	HUAIROU Commission of the Global Coalition of Women and AIDS
Kenya	Mr. Jeffrey Walimbwa	Civil Society Programme Officer	ISHTAR MSM
Kenya	Natalia Winder Rossi	Senior Social Policy (Social Protection) Specialist	UNICEF
Lesotho	Ms. Mamello Makoae	Executive Director	Lesotho Network of AIDS Service Organizations

			(ENASO)
Lesotho	Mr. Tlelase Ausiel Mokhele	Coordinator	Young Positive Network
Madagascar	Dr. Miaro Zo ANDRIANOELINA	Technical Support and Strategic Planning Process Department	National AIDS Committee
Malawi	Mr. Davie Kalomba	Acting Executive Director	NAC Malawi
Malawi	Ms. Mary Pat Kieffer		Elizabeth Glaser Pediatric AIDS Foundation
Malawi	Rev. MacDonald Sembereka	Executive Director	MANERELA+
Mozambique	Mr. Rui Joaquim Maguene	Disability & HIV Advisor	Civil Society Platform
Namibia	Mr. Casper Erichsen	Executive Director	Positive Vibes
Namibia	Dr. Norbert Forster	Deputy Permanent Secretary	Ministry of Health and Social Services
Namibia	Tikhala Itaye	Vice President	AfriYAN Namibia
Seychelles	Mr. Ronny Arnephy	Président	Ravane Océan Indien
Seychelles	Mrs. Peggy Vidot	Principal Secretary	Ministry of Health
South Africa	Dr. Fareed Abdullah	Chief Executive Officer	SANAC
South Africa	Asa Anderson	Regional Programme Coordinator (SRHR-HIV Linkages)	UNFPA
South Africa	Ms. Anu-Elina Autio	Second Secretary External Economic Affairs & Culture	Embassy of Finland
South Africa	Bernd Appelt?	HIV/AIDS Prevention Programme	GIZ
South Africa	Thanduxolo Doro		Network of African People Living Positively, African Region (NAP+SAR)
South Africa	Valentine Douala Mouteng		Standard Bank
South Africa	Amanda Banda		MSF Belgium, South Africa
South Africa	Dumisani Gandhi		Canadian Government
South Africa	Dr. Vanessa Govender	Chairman of the Board	SABCOHA – South African Business Coalition on Health & AIDS
South Africa	Shungu Gwarinda	Country Director	Mothers2Mothers
South Africa, Swaziland	Onias Hlungwani	Advocacy Manager	Voluntary Services Overseas- Regional AIDS Initiative Southern Africa (VSO-RAISA)
South Africa	Mary Kau		Swedish Workplace HIV/AIDS Programme
South Africa	Bafana Khumalo	Sonke Gender Justice,	Sonke Gender Justice
South Africa	He-Jin Kim	Regional LGBTI Programme Officer	Aids and Rights Alliance Southern Africa (ARASA)
South Africa	Naume Kupe	ESA Programme Manager	RIATT
South Africa	Nicole Fraser	M&E Specialist	World Bank
South Africa	Simphiwe Mabhele		ILO

South Africa	Patricia Machawira	Regional Adviser HIV/AIDS	UNESCO
South Africa	Joan Marston	Chief Executive	International Children's Palliative Care Network
South Africa	Buhle Mabaso		SAfaids
South Africa	Tamara Mathebula	Health, HIV and AIDS Adviser	Irish Aid/Embassy of Ireland
South Africa	Reiko Matsuyama		IOM
South Africa	Hilary Mathews	Consultant	UNAIDS
South Africa	Asha Mohamud	Youth Specialist Advisor	UNFPA
South Africa	Daniel Molokele	Executive Director	AIDS Accountability International
South Africa	Erasmus Morah	Country Director	UNAIDS South Africa
South Africa	Sethembiso Mthembu	Regional Director	ICWSA (in full)
South Africa	Mrs. Lynette Mudekunye		Regional Psychological Support Initiative (REPSSI)
South Africa	Dr. Dirk H. Mueller	Regional Health Adviser	DFID Regional Office
South Africa	Busi Nkosi	Advocacy Director	International Children's Palliative Care Network
South Africa	Ms. Nadia Ottiger	Head of Domain, HIV/AIDS	Swiss Agency for Development and Cooperation
South Africa	Matseliso Pule		SANAC
South Africa	Natalie Ridgard	Communications Adviser	UNAIDS South Africa
South Africa	Petro Rousseau	Prevention Advisor	SANAC
South Africa	Rev Sekete	Program Manager	National Network of Religious Leaders Living with and Personally Affected by HIV and AIDS, Africa Region (INERELA+/Africa)
South Africa	Tlangelani Shilubane	HIV Prevention Specialist	UNFPA
South Africa	Erin Tansey	HIV Advisor	WFP
South Africa	Dr. Heidi Van Rooyen	Research Director	Human Science Research Council (HSRC)
South Africa	Lyn van Rooyen	Director	CABSA
South Africa	Ricardo Walters		Out of Phase Facilitation, Consulting, and Support Services
South Africa	Nonhlanhla Xaba	HIV/AIDS Programme Officer	WFP
South Sudan	Hon. Dr. Esterina Novello Nyilok	Chairperson	South Sudan AIDS Commission (SSAC)
Swaziland	Hon. Sibongile Ndlela-Simelane	Minister of Health	Ministry of Health

Swaziland	Dr. Velephi Okello	Deputy Director of Health Services	Ministry of Health
Tanzania	Dr. Fatma Mrisho	Executive Chair	Tanzania Commission for AIDS (TACAIDS)
Tanzania	Olive Mumba	Acting Executive Director	Eastern Africa National Networks of AIDS Service Organizations (EANNASO)
Uganda	Musah El-nasoor Lumumba	Team Leader	Uganda Youth Coalition on Adolescent Sexual and Reproductive Health Rights and HIV/AIDS (Uganda),
Uganda	Michela Martini	HIV Advisor ESA Uganda Coordinator	IOM
Uganda	Lydia Mungherera	Chief Executive Officer	ICW and Mama's Club
Zambia	Hon. Dr. Chitalu Chilufya	Deputy Minister of Health	Government of Zambia
Zambia	Dr. Jabbin Mulwanda	Director General	National HIV/AIDS/STI and TB Council
Zambia	Mr. George Nyendwa	Mayor of Lusaka	Zambia - Mayor of Lusaka
Zambia	Kenly Sikwese	Coordinator	AFROCAB
Zimbabwe	Yunah Bvumbwe	Outreach Officer	Youth Engage, Zimbabwe
Zimbabwe	Lois Chingandu	Civil Society Officer	SAfaids
Zimbabwe	Angeline Chiwetani	Executive Director	Widows Fountain of Life (WFoL)
Zimbabwe	Tapiwanashe Kujinga	Civil Society Officer	PATAM
Zimbabwe	Dr. Tapuwa Magure	CEO	NAC Zimbabwe
Zimbabwe	Dr. Fabian Ndenzako	HIV/AIDS Focal Point	WHO (IST/ESA)
Zimbabwe	Philimon Simwaba		Disability HIV and AIDS Trust (DHAT)
Zimbabwe	Tendayi Westerhof	Secretary	PAPWC
USA	Jamila Headley	Managing Director	Health Gap
UNAIDS	Dr. Kent Buse	Chief of Strategic Policy Directions	UNAIDS HQ
UNAIDS	Dr. Mbulawa Mugabe	Director of Country Impact and Sustainability	UNAIDS HQ
UNAIDS	Dr. Joel Rehnstrom	Director of Planning and Finance	UNAIDS HQ
UNAIDS	Fode Simaga	Senior Programme Advisor, EXO	UNAIDS HQ
UNAIDS	Dr. Sheila Tlou	Regional Director	UNAIDS RST-ESA
UNAIDS	Dr. Pierre Somse	Deputy Director	UNAIDS RST-ESA
UNAIDS	Sandra Aslund	Project Officer (Sida)	UNAIDS RST-ESA
UNAIDS	Eleanor Gouws	Senior Strategic	UNAIDS RST-ESA

		Information Advisor	
UNAIDS	James Guwani	Strategic Information Advisor	UNAIDS RST-ESA
UNAIDS	Jane Kalweo	Global Outreach Advisor	UNAIDS RST-ESA
UNAIDS	Felicity Khoza	Programme Assistant: Directorate	UNAIDS RST-ESA
UNAIDS	Paska Kinuthia	Youth and Social Organization Officer	UNAIDS RST-ESA
UNAIDS	Michel Kouakou	Regional Operations Manager	UNAIDS RST-ESA
UNAIDS	Charity Makanda	UNAIDS RST-ESA	UNAIDS RST-ESA
UNAIDS	Jacqueline Makokha	Senior Community Mobilization Advisor	UNAIDS RST-ESA
UNAIDS	Faith Mamba	Senior Investment & Efficiency Advisor	UNAIDS RST-ESA
UNAIDS	Sophia Mukasa Monico	Senior Gender Advisor	UNAIDS RST-ESA
UNAIDS	Bechir Ndaw	Senior Human Rights & Law Advisor	UNAIDS RST-ESA
UNAIDS	Caroline Ntchatcho	Executive Officer	UNAIDS RST-ESA
UNAIDS	Petrus Phiri	Senior Transport Manager	UNAIDS RST-ESA
UNAIDS	Jyothi Raja	Senior Strategic Interventions Advisor	UNAIDS RST-ESA
UNAIDS	Iris Semini	Senior Investment & Efficiency Advisor	UNAIDS RST-ESA
UNAIDS	Saul Sengane	Transport Manager	UNAIDS RST-ESA
UNAIDS	Gregory Smiley	Strategic Interventions Advisor	UNAIDS RST-ESA
Consultant	Peter Godwin	Consultant	UNAIDS RST-ESA
Consultant	Mary O'Grady	Consultant	UNAIDS RST-ESA
Consultant	Philip Schedler	Photographer	

Annex 2: Programme at the one-day consultation

Programme Outline Eastern and Southern Africa Regional consultation on UNAIDS Strategy 2016 - 2021 Monday 23 March 2015 0800 – 1730 Crown Plaza Hotel, Rosebank – Sandton, Johannesburg		
Monday 23 March 2015		
Time	**Agenda**	**Facilitator /presenter**
0730 – 0815	Registration	
0815 - 0830	Opening remarks and objectives of the consultation Review of days programme and participants expectations	Dr. Pierre Somse; Deputy Director, UNAIDS RST ESA Peter Godwin, Lead Facilitator
Session 1: Setting the scene		
Session Chair: Dr Fatma Mrisho, Tanzania Commission for AIDS (TACAIDS)		
0830 - 0840	Video streaming	
0840 - 0900	Welcome and overview of the epidemic and the response in the region	Prof. Sheila Tlou, Director, UNAIDS Regional Support Team, ESA
	Plenary discussion	
0900 - 0920	Fast track to end AIDS by 2030 - UNAIDS Strategy 2016 -2021: Overview (plenary presentation)	Mbulawa Mugabe, Director, Country Impact and Sustainability; UNAIDS Geneva Kent Buse, Chief, Strategic Policy Directions, UNAIDS Geneva
0920 – 1000	**Plenary discussion**	
1000 – 1020	Introduction to the breakout sessions	Peter Godwin, Lead Facilitator
Session 2: Break-out sessions to respond to key questions – detailed guidance for group work to be provided		
1020 – 1300		Thematic group work - Chair; Technical discussant; Rapporteur, Name of Room
Round table on high level political agenda for HIV Post 2015		Convenor: Prof. Sheila Tlou Rapporteur: Iris Semini Room: Executive Boardroom

Session 2: Break-out sessions to respond to key questions – detailed guidance to be provided		
1020 – 1300		**Thematic group work - Chair; Technical discussant; Rapporteur, Name of Room**
Round table on high level political agenda for HIV post 2015		Convenor: Prof. Sheila Tlou Rapporteur: Iris Semini Room: Executive Boardroom
Group 1: Prevention with a focus on key populations, populations left behind; sexual transmission, girls and young women, and youth		Chair: Dr Norbert Foster Technical discussant: Wanjiku Kamau Rapporteur: Greg Smiley Room: Dalasi
Group 2: HIV Treatment and EMTCT: the integrated response		Chair: Dr. Velephi Okello Technical discussant: Dr Fabian Ndenzako Rapporteurs: Bizwick Mwale Room: Pula
Group 3: Human rights and social justice: Participation and equity		Chair: Rev. MacDonald Sembereka Technical discussant: Rapporteur: Kitty Grant Room: Kwacha
Group 4: Gender: Equality and gender-based violence		Chair: Prof Rachel Jewkes Technical Discussant: Samantha Williams Rapporteur: Violet Shivutse Room: Dinar
Group 5: Community level engagement in service delivery: demand, supply and accountability		Chair: Lois Chingandu: Technical discussant: Ricardo Walters Rapporteur: Tendayi Westerhof Room: Cedi
Group 6: Political commitment: the hard choices		Chair: Dr Takuwan Magure Technical discussant: Prof. Nana Poku Rapporteur: James Guwani Room: Nakfa
Group 7: Sustainability: efficiency, innovation and integration		*Chair:* Mr Tshepho Mophuting Technical discussant: Davie Kalomba Rapporteur: Faith Mamba Room*:* Breakout room 1st floor (name TBC)
1300 - 1430		**Lunch break**
Session 3: Report Back and feedback from participants		
Session Chair: Dr. Jabbin Mulwanda, DG, National HIV/AIDS/STI and TB Council, Zambia		
1430 - 1500	**Plenary discussion –** 'Game-changers'?	
1500- 1630	Presentation of group outputs & discussion	Peter Godwin, Lead Facilitator
1630 – 1645	**Coffee/tea Break**	
Session 4: Closing		
Session Chair: Dr Tapuwa Magure, CEO, NAC Zimbabwe		
1645 - 1700	Partnership platform to Fast-Track the ESA AIDS response	Dr. Pierre Somse, Deputy Executive Director, UNAIDS ESA
1700 - 1730	Ministers of Health panel on way forward **Closing**	
1800 - 2000	Refreshments	