

Lessons learnt from the multi-sectoral approach in the fight against HIV/AIDS

**Be-cause health Seminar
Putting People at the Heart of Development.
Sexual and Reproductive Health and Rights in the post-2015 era.**

28 November 2014, Brussels

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Background of this meeting – Personal Anecdote

The review of the implementation of the ICPD Programme of Action, 20 years later, highlighted that though significant progress has been made, many challenges remain.

- Maternal mortality stays unacceptably high, access to family planning is far from universal and sexual and gender-based violence is still endemic. Adolescents and youth in particular remain exposed to high risks of unwanted pregnancies, unsafe abortions, STIs and HIV.
- Social and cultural norms and values still hamper access to accurate and comprehensive sexual and reproductive health information. **Stigma, discrimination and even criminalization of key populations such as sex workers and sexual and gender minorities, prevent them from accessing reproductive health services.**
- Experience has demonstrated that **the fight against HIV and AIDS has benefited from a multi-sectoral approach.** In this session we want to illustrate how the multi-sectoral approach can be used to promote SRHR.

Overview

- The multi-sectoral response to HIV/AIDS
- Applying a multi-sectoral approach at country level
- Conclusions and Recommendations

Progress: The beginning of the end of AIDS -

2001 UNGASS Declaration

Deeply concerned that the global HIV/AIDS epidemic, through **its devastating scale and impact, constitutes a global emergency and one of the most formidable challenges to human life and dignity, as well as to the effective enjoyment of human rights, which undermines social and economic development throughout the world** and affects all levels of society — national, community, family and individual;

Concerned also that the continuing spread of HIV/AIDS will constitute a serious obstacle to the realization of the global development goals we adopted at the Millennium Summit of the United Nations;

2014 Ending the AIDS epidemic.

Ending the AIDS epidemic—four words that hold such hope and promise. Four words that represent more than 30 years of devastation, struggle and loss.

...

Activism and research led to one of the most effective global movements of this generation.

Global commitment and clear goals paved the way for countries at the start of the AIDS response. Then resources, innovation and communities accelerated its progress.

There will be no ending AIDS without putting people first, without ensuring that people living with and affected by the epidemic are part of a new movement. Without a people-centred approach, we will not go far in the post-2015 era.

Michel Sidibe, Foreword of the GAP report

Zero new HIV infections.
Zero discrimination.
Zero AIDS-related deaths.



2014 Success & remaining challenges

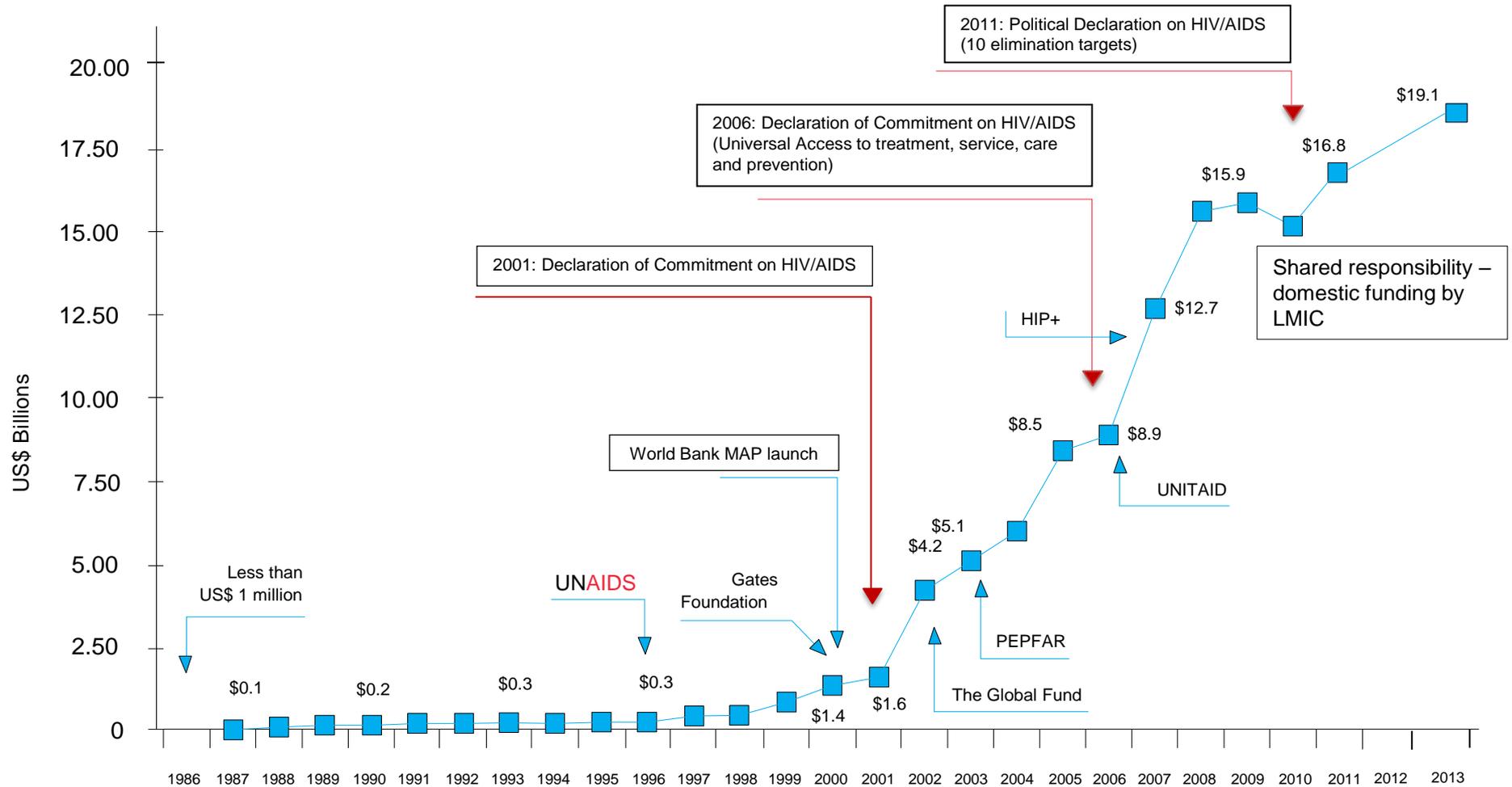
- 🚫 Global new HIV infections: -38% from 2001.
 - 🚫 2.1 million new HIV infections >80% in 20 countries
- 🚫 Stopping new HIV infections among children: -58% from 2002
 - 🚫 But still 240,000 in 2013
- 🚫 AIDS-related deaths: -35% since 2005.
 - 🚫 1.5 million deaths
 - 🚫 Leading cause of death among young women in Sub-Saharan Africa (?)
- 🚫 More people on ARV than ever before (12.9 million end of 2013),
 - 🚫 i.e. the % of people not yet receiving ARV has been reduced from 90% to 63% since 2006

Zero new HIV infections.
Zero discrimination.
Zero AIDS-related deaths.



Global financial resources and needs for HIV/AIDS

Global resources available for HIV, 1986-2013



2001 - UN General Assembly Special Session on AIDS

“Towards a global alliance”

*“For there to be any hope of success in the fight against HIV/AIDS, **the world must join together in a great global alliance.** The Declaration of Commitment on HIV/AIDS is the culmination of a year-long process of awareness, engagement and mobilization. My great hope is that it signals the emergence of a response to this deadly disease — by **Governments, multilateral organizations, the private sector and civil society — that could soon match the scale of the epidemic itself.**”*

Kofi A. Annan

United Nations Secretary-General

First paragraph of the Foreword to the UNGASS declaration



People at the centre of the multi-sectoral response

1994 - People living with HIV - GIPA principle

- The GIPA Principle was formalized at the 1994 Paris AIDS Summit when 42 countries agreed to :

“support a greater involvement of people living with HIV at all levels and to stimulate the creation of supportive political, legal and social environments”.

“The participation and contribution of people living with HIV is one of the best examples of global progress in public health. We have come from a place where people openly living with HIV were stoned to death, to a place where we have been invited to stand among the leaders of the world to shape international policies. There is still a long way to walk but we have made historical changes and gains of which we can be proud.”

Gracia Violeta Ross, National Chair, Bolivian Network of People Living with HIV/AIDS

Defining a multi-sectoral approach

The Commonwealth Think Tank Meeting held in London in July 2001 defined a multi-sectoral response to HIV/AIDS as follows:

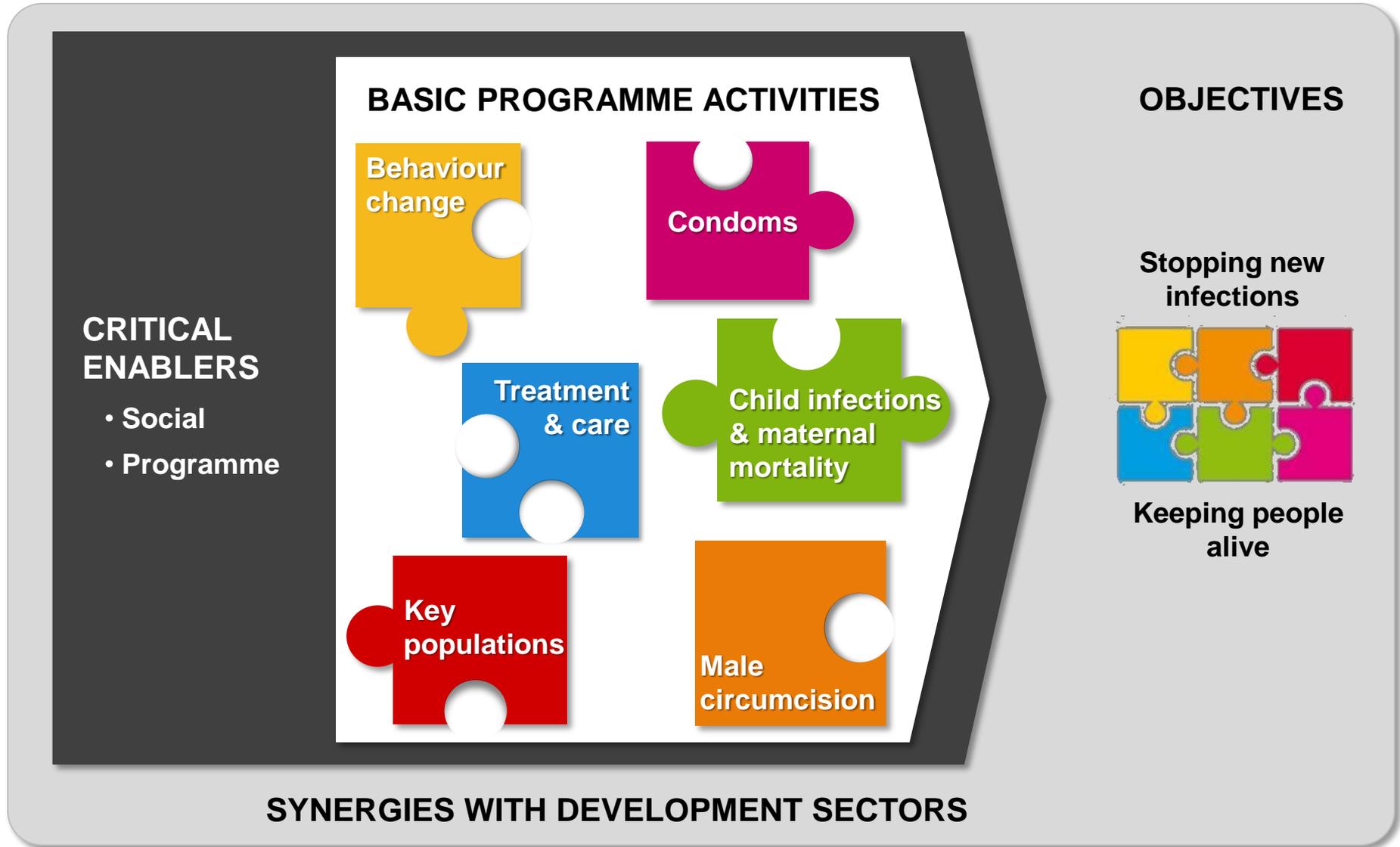
*"A multi-sectoral response means involving **all sectors of society** - governments, business, civil society organisations, communities **and people living with HIV/AIDS, at all levels** - international, national and community - in addressing the causes and impact of the HIV/AIDS epidemic.*

*Such a response requires action to engender political will, leadership and coordination, **to develop and sustain new partnerships and ways of working**, and to strengthen the capacity of all sectors to make an effective contribution."*

Key milestones in the Multi-sectoral Response to HIV/AIDS

- 1985-1995: Initial “narrow” health response to the new epidemic
- 1990-1995: From a health to development issue and approach
- 1990-2000: UNDP AIDS & Development Initiative. Mainstreaming of HIV
- **1993: Uganda adopts a multi-sectoral response to HIV/AIDS prevention;**
- 1994: GIPA principle – Paris declaration
- **1996: Creation of UNAIDS**
- 1998: UNAIDS Guidance for of multi-sectoral national strategic plans on AIDS
- 1999-2000: World Bank MAP Project
- 2001: UNGASS
- 2002: Creation of the Global Fund
- 2003: The Three Ones principles (Nairobi)
- 2003: launch of PEPFAR
- 2006: UN Political declaration on Universal Access
- **2011: Investment Framework**
- 2011: HLM 10 Targets & commitments & prominence of integration integration
- 2014: Ending AIDS by 2030 and HIV/AIDS and the post-2015 development agenda

AIDS: investing strategically to maximize impact



Définition des concepts clés: Synergies de développement

Synergies de développement = investissements dans d'autres secteurs que le VIH qui ont des effets positifs sur les résultats du VIH

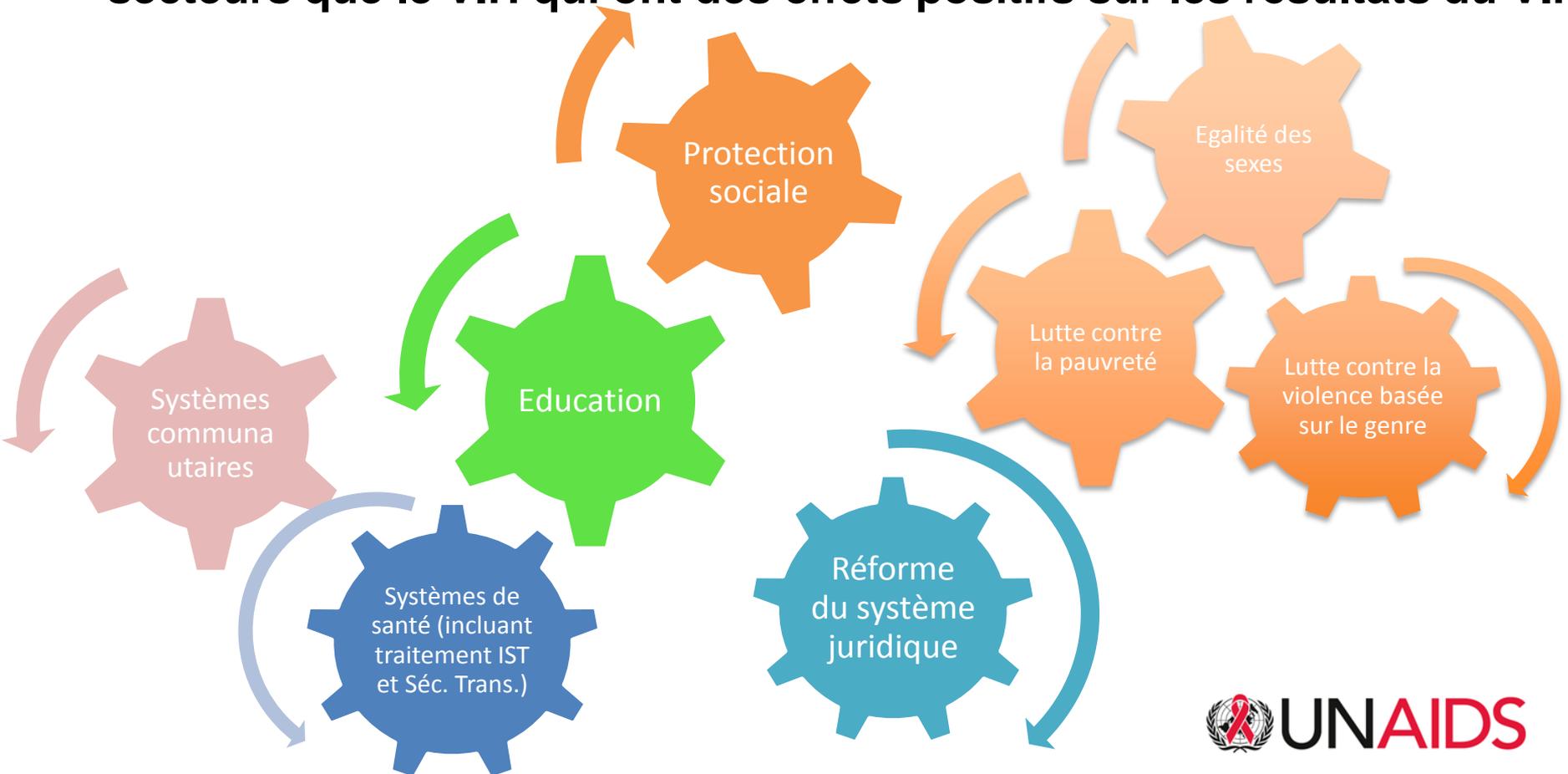
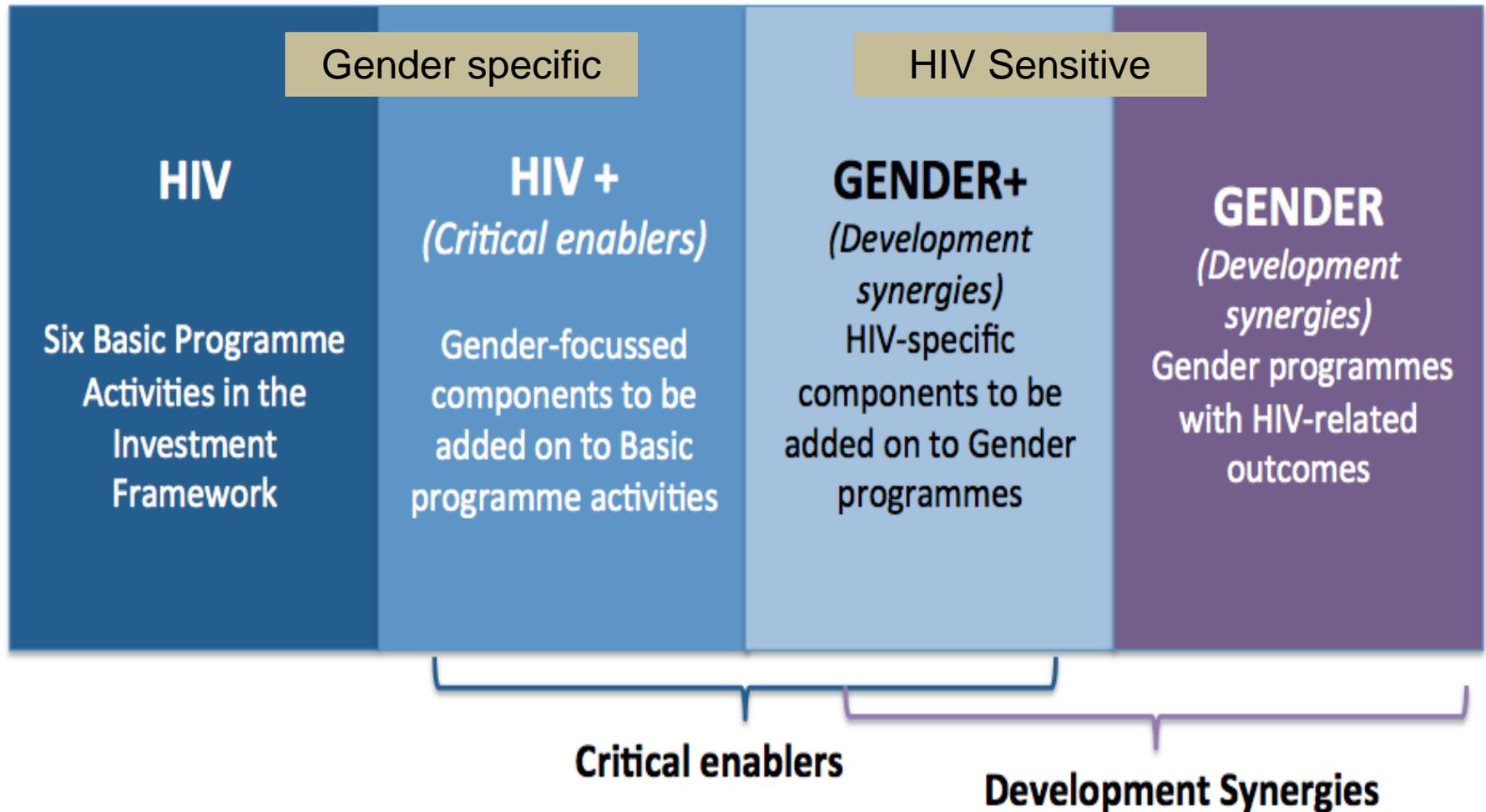


Figure 1: Conceptual framework: gender integration, critical enablers and development synergies
(adapted from the London School of Hygiene and Tropical Medicine) (source UNDP)



A this figure illustrates, addressing gender in the context of HIV operates along a spectrum, balancing attention to HIV with attention to gender. It is important to keep in mind that basic programme activities represented in the first box on the left would necessarily include the gender-related elements of basic programme activities, and “gender” activities (represented by the box on the far right) should encompass relevant HIV and health-related concerns.

About UNAIDS

- ✚ Innovative joint venture of the United Nations (UNAIDS Secretariat + 11 UN system organizations – “cosponsors”)
- ✚ Established in 1994 by an **ECOSOC resolution**, launched in January 1996
- ✚ Guided by a **Programme Coordinating Board (PCB)**, consisting of
 - 22 governments from all geographic regions
 - 11 UNAIDS Cosponsors
 - 5 NGOs from all geographic regions, including associations of people living with HIV
 - Secretariat based in Geneva, around 70 country offices

UNAIDS 2011-2015 Strategy



Zero new Infections.
Zero Discrimination.
Zero AIDS-related deaths.

Zero new HIV infections.
Zero discrimination.
Zero AIDS-related deaths.

Zero Discrimination

At equal level of priority as prevention & treatment by recognising that "*stigma & discrimination*"
1) have major impact on quality of life of PLHIV
2) are the main barriers to scaling up services and ending AIDS

Country examples - Namibia

- Applying a people centred multi-sectoral response to overcome stigma & discrimination
 - Sexworkers
 - PLHIV
 - Gender-based violence

Universal Access in Namibia: a Success story

“Five years ago, when the international community committed to Universal Access, there were many who believed it was only a dream. Namibia has shown that this dream can become a reality.”

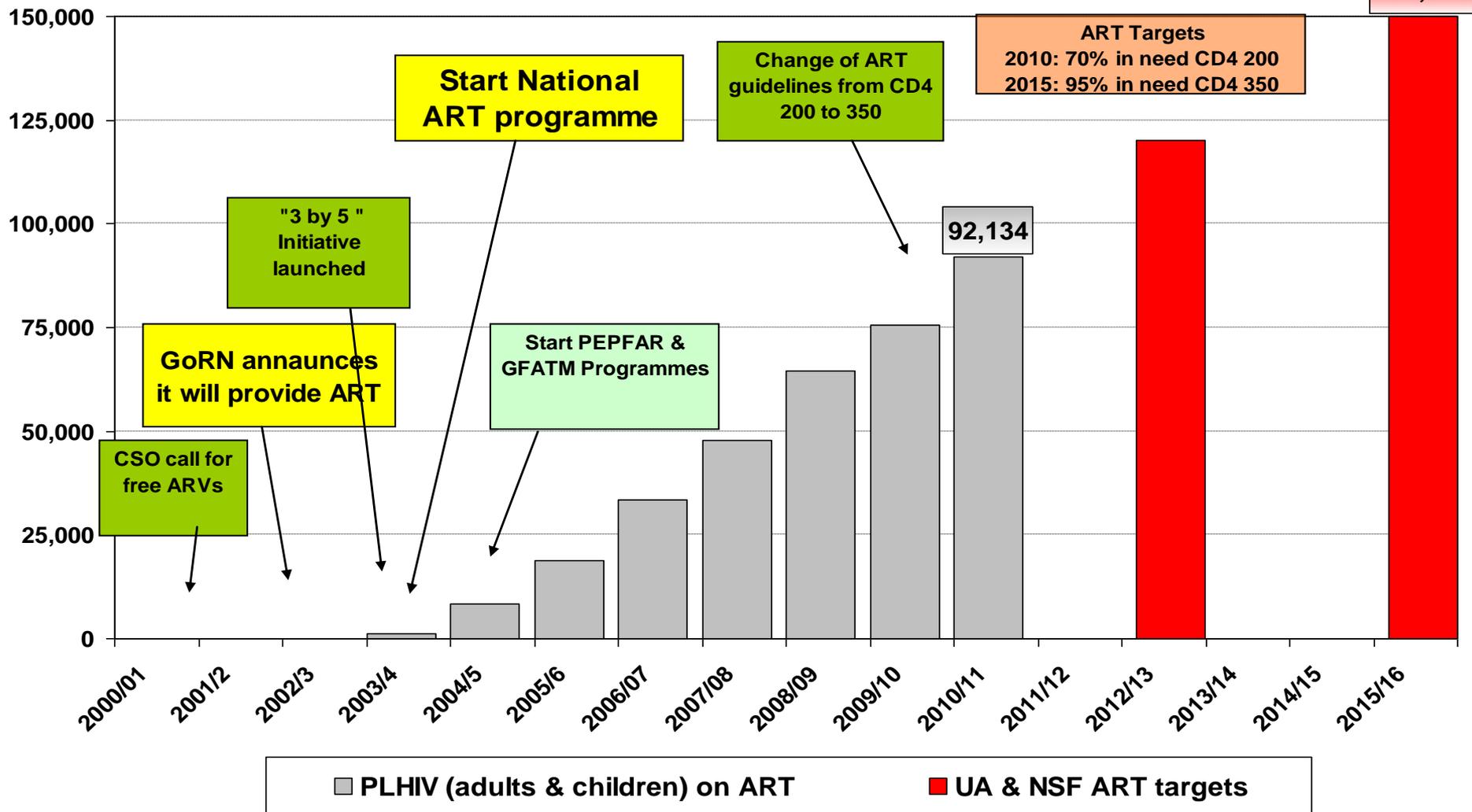


Impact on lives	2002 -2011
Nbr of HIV infections averted	>65,000
Nbr of pediatric HIV infections averted	6,000
Nbr of lives saved	>50,000
Nbr of children not orphaned	>75,000

“Namibia has exceeded its 2010 Universal Access targets for antiretroviral therapy and prevention of mother-to-child transmission of HIV and is covering close to 50% of the national response from domestic resources. Namibia is one of the few countries to demonstrate such success towards Universal Access.”

*Michel Sidibé, UNAIDS Executive Director,
Windhoek April 2011*

Number of PLHIV receiving ART



Namibia – A Universal Access success story but can we end AIDS in Namibia?

- A success story in terms of Universal Access and political commitment
- Response mainly Health sector & Commodity driven
- Confronted with major systemic & sustainability challenges
- Multi-sectorality of the response under pressure
 - Funding decrease in particular civil society
 - 3 ones instruments not functional
 - Participation (PLHIV network collapsed)
 - Widespread Stigma and discrimination, incl. in health sector
- Unsufficient attention & action towards the social & structural determinants of HIV
- HIV/AIDS epidemic occurs in context of other major public health and social challenges including GBV
 - Unsufficient leverage of the AIDS response as a pathfinder for social justice

Example 1: Empowering sex workers

- **UNAIDS/UNFPA initiative to empower sex workers to overcome the duty bearers “discourse trap” to justify in-action on key populations.**
- The following chain of arguments is being used by “duty bearers” in various combinations:
 - These people (SW, MSM, ...) are already lost and it’s their own fault (variation - this is against the bible and its divine punishment)
 - It is illegal hence we/government [and those working with cannot do anything!
 - These people are not coordinated, don’t have the capacity and cannot be trusted hence we cannot work with them [invest resources]
 - Our public health services are available for everyone and key populations are free to access them
 - We don’t have sufficient evidence to plan interventions (the obsession with KP size estimates ...) ... we need to do a study.

Sex work and HIV- Reality on the ground:

Rapid assessments in five towns in Namibia



“Stigma starts with the law itself”

“Sex workers got rehabilitated by Ministry of Health but most of them went back to sex work after the training”

“I don’t know what rights I have”

“We have tried to contact the police but they don’t help”

“The police say it [sex work] is illegal and they beat us with zambucks, they chase us into bushes”

“The government does not take us seriously”

“The police hit us on the streets and we are brutally abused where it is isolated and dark by the police”

“when its late... and the superiors go home the officers on duty use to book us out and take us to their places [to] have sex with us, make us clean their places then chase us”



Table 1: Rapid assessment activities conducted

Town	Number of FGDs	Number of participants
Kalkrand	3	25
Katima Mulilo	4	31
Oshikango	4	27
Walvis Bay	8	47
Windhoek	10	82

Sex work, HIV and Access to Health Services in Namibia:

National meeting report and recommendations



UNAIDS
JOINT UNITED NATIONS PROGRAMME ON HIV/AIDS

UNICEF
UNEP
UNFPA
UNHCR

UNODC
ILO
UNESCO
WHO
WORLD BANK



Example 2: Empowering PLHIV - PLHIV support groups in Windhoek



SUPPORT GROUPS OF
PEOPLE LIVING WITH
HIV IN WINDHOEK,
NAMIBIA

A MAPPING

- Mapping revealed existence of 50+ PLHIV self-support groups in informal settlements bringing together 1500 PLHIV, mostly women, mothers, single without stable income
- Although most women accessed treatment none of the groups received support from city, line ministries or CSO
- Missed opportunity to support the poorest & most vulnerable and build social capital and enhance civil participation

July 2010: Lifting travel restrictions for PLHIV

- 3rd country in the world after US and China
- Collaborative effort between Civil Society, PLHIV, Development partners and involving the Prime Minister, Ministry of Home Affairs, Ministry of Health and Ministry of Justice
- Impact beyond HIV also lifted the restrictions for a series of other diseases
- UNAIDS as a broker

Women living with HIV at the forefront to eliminate new HIV infections among children and keep mothers alive

Stakeholder Consultation
Meeting Report
20-21 June 2012



COMMUNIQUÉ - National PLHIV Consultation Conference

June 28, 2013 - Windhoek, NAMIBIA

- The third national consultation of people living with HIV (PLHIV) was held from 26-28 June 2013 at the Roof of Africa Conference Centre in Windhoek. The conference brought together representatives of the PLHIV community from all of Namibia's 13 regions, as well as development partners, representatives from civil society and the Ministry of Health and Social Services, and key stakeholders in the national AIDS response. The main purpose of this consultation conference was to explore opportunities for involvement, representation and coordination of PLHIV in Namibia's national AIDS response. Following deliberations, the delegates hereby issue the following communiqué.

After three days of extensive deliberations, we have observed the following issues, and in response, provide recommendations to address the identified areas of concern:

- **1. The delegates expressed concern about ARV stock outs in certain regions, in particular the Omusati region, as mentioned in local media on Wednesday (26 June 13), and call on the Ministry of Health and Social Services to ensure that adequate supplies of these life-saving drugs are available to all people living with HIV who have been enrolled on ART;**
- 2. The conference noted with concern reports from some regions, including Erongo and Kavango, that in certain health facilities patients are given expired ARVs. In response to this dangerous practice, the delegates call on the Ministry of Health and Social Services to ensure that all drugs prescribed to patients are in compliance with the guidelines of the Ministry of Health and Social Services and the World Health Organisation (WHO);
- 3. The conference discussed the disparities between treatment protocols used by public and private doctors and calls on government to enforce standards and regulations pertaining to ART at all health care facilities;
- 4. Delegates decried continuing reports of discrimination and stigmatisation by healthcare personnel at public facilities. The conference calls on government to declare a policy of **"Zero Tolerance"** for discrimination in the provision of healthcare in Namibia to ensure that all individuals who need services are provided them in a manner that upholds their dignity and respects the rights of all individuals; The conference further urges that this policy be extended to all sectors of society (e.g.: employment, education, insurance, banking);
- **5. The conference raised concerns over reported incidences in which HIV positive pregnant women have been forced to default from ARV treatment due to coercion and discrimination experienced when trying to access PMTCT services at public health care facilities. Therefore, the delegates call on the Ministry of Health and Social Services to ensure that all staff are well trained to provide high-quality services in a non-discriminatory manner that respects patient's sexual, reproductive, and health rights;**
- 6. The conference noted continued challenges in accessing ART services because of long distances to health care facilities, and calls on government to carefully study the availability of health care facilities and ART clinics to ensure that all Namibians can access needed services in convenient locations, and to make provisions to address barriers, such as lack of transport which limits access to ART for PLHIV;
- 7. The delegates expressed concern over the lack of appropriate space in some healthcare facilities for HIV counselling and testing services and the dispensing of medication in a confidential manner. Therefore, the conference calls on the Ministry of Health and Social Services to ensure that the physical space of HIV services located in public health care facilities does not create barriers or discourage individuals from accessing services because of a lack of confidentiality offered by inadequate physical spaces;
- 8. PLHIV representatives noted the disparities in the provision of counselling services in various ART clinics. PLHIV representatives call on the Ministry of Health and Social Services to ensure the provision of continuous, high-quality and standard HIV counselling services;
- 9. The delegates expressed concern over the lack of continuing care services, such as case management services, available to PLHIV, and call on the Ministry of Health and Social Services to utilise the "expert patient" and Community Health Care Workers programme to expand HIV outreach services;
- 10. The delegates debated the lack of an enabling environment, based on reports that government employees living with HIV are denied relief from their positions to participate in PLHIV-oriented gatherings and events. Therefore, the conference calls on government to demonstrate full support for GIPA implementation by granting temporary relief from work duties to participate in PLHIV gatherings and activities;



COMMUNIQUÉ - National PLHIV Consultation Conference (2/2)

- **11. The delegates expressed concern over the lack of user-friendly services available to members of key populations, including sex workers, MSM, transgender individuals, prisoners, mobile populations, etc. and calls on the Ministry of Health and Social Services to ensure that the needs of these populations are taken into consideration when planning and implementing services;**
- 12. The delegates lamented the non-functionality of key National Coordinating Structures, especially the National AIDS Council (NAC) which has not met since the 2011 implementation of the National Strategic Framework (NSF), and calls on government to ensure that all decision-making and coordinating structures as described in the National Coordination Framework are operational and to establish an accountability mechanism to monitor their functionality;
- 13. The delegates noted the start of the NSF Mid-Term Review process, and welcome the opportunity for PLHIV to be engaged. In response, the conference calls on government to ensure that this process is transparent and that it includes the perspectives of all stakeholders, in particular PLHIV, in all areas of the review, including regional consultations and assessments and inclusion of PLHIV representatives in the steering committee;
- 14. The delegates expressed concern about the lack of PLHIV representation in the national coordinating structures, namely the TACs, Sector Steering Committees, and the National AIDS Council. Conference delegates call on government to amend the terms of reference for these groups to formally include PLHIV representatives in these structures. Further, resources should be allocated by the government to facilitate the inclusion and meaningful participation of PLHIV in the national coordinating structures;
- 15. The conference applauded government's prioritisation of HIV prevention, but note with concern that medical aid for public servants excludes artificial insemination for discordant couples. The delegates call on government to ensure that all services which can reduce the transmission of HIV are covered by medical aid schemes;
- **16. The conference condemns the continued discrimination against PLHIV by life insurance and medical aid insurance providers, and calls on government to engage with the private sector in order to facilitate equal access to insurance services to all Namibians, irrespective of their HIV status;**
- 17. The delegates noted with concern that some foreign governments advertise scholarship opportunities to Namibians, but specifically exclude applicants who are HIV-positive. The delegates call on government to work with foreign government/university representatives to ensure that all qualified applicants, regardless of HIV status, are given the opportunity to apply for these scholarships;
- 18. The delegates noted with concern that in certain facilities, the new treatment guidelines are not being applied. The delegates call on the Ministry of Health and Social Services to update the treatment guidelines to comply with WHO recommendations. Further, the delegates encourage the Ministry of Health and Social Services to insure treatment is on par with the private health care settings, and to phase out the use of drugs that are known to increase the risk of resistance.
- In conclusion, we confirm that the PLHIV community in Namibia is committed to the national response to HIV and to developing capacity at individual, community and national levels.

3 November 2014: Namibia Supreme court ruling in favour of women living with HIV sterilised without consent

CASE NO: SA 49/2012 IN THE SUPREME COURT OF NAMIBIA

In the matter between: **GOVERNMENT OF THE REPUBLIC OF NAMIBIA**, Appellant and **LM (First Respondent)**, **MI (Second Respondent)**,
NH Third Respondent

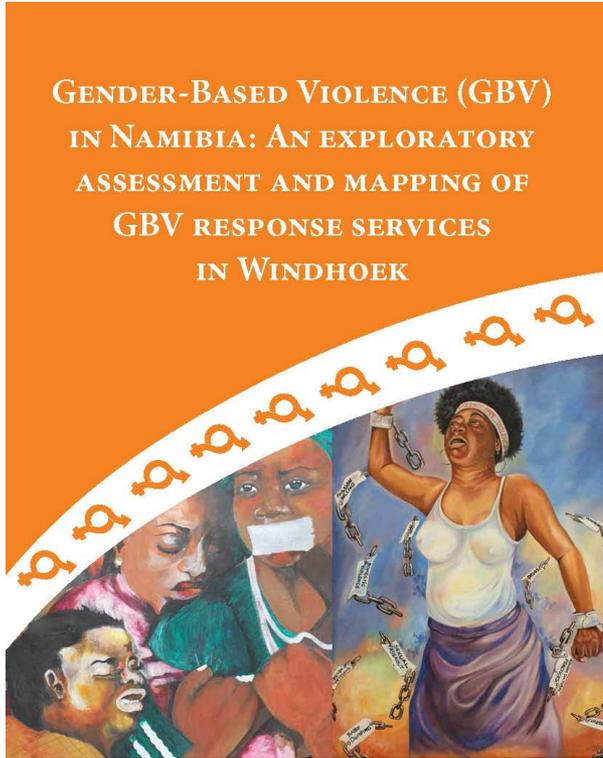
- ...
- [109] For all these reasons, **it is my considered opinion that none of the respondents gave informed consent** because they were in varying degrees of labour and may not have fully and rationally comprehended the consequences of giving consent for the sterilisation procedure. This is especially the case given that none of the respondents made any appointment or booking to confirm their intention to be sterilised before going into labour.
- [110] In my view, **the appeal in respect of each of the respondents ought to be dismissed** and the matter referred back to the High Court for the determination by that court of the quantum of damages payable by the appellant.
- [111] Counsel appearing for the respondents argued the appeal on instructions from the Legal Assistance Centre (LAC) and has informed us that in the light of the LAC's legal status, she was instructed not to ask for a costs order. Therefore no order as to costs will be made.
- [112] The following order is made:
- **1. The appeal in respect of each of the respondents is dismissed.**
- **2. The matter is remitted to the High Court for the determination of the quantum of damages.**

Example 3: Namibia: No ending AIDS without ending Gender based Violence



President Pohamba declared 6 March as the national day of prayer for action against GBV in Namibia. “The lives of too many women and girls have been destroyed or disrupted,” said President Pohamba. “Gender-based violence, in all its manifestations, should not be tolerated in Namibia. Let us join hands, to make our country safer, for all, including our women and girls.”

Namibia - Using HIV as an entry point to address Gender-based violence



Young Namibians vote to end AIDS and GBV at the top of Mount Brandberg, April 2013



Some progress

- New NSP and National combination prevention strategy explicitly acknowledge and prioritise gender and GBV as key drivers of the epidemic.
- SRH/HIV service integration is a priority for the Ministry of Health
- Supported by initiatives at regional level in Eastern and Southern Africa on HIV prevention for women and girls in high prevalence countries in ESA and HIV/SRH service integration.

A CALL TO ACTION: URGENT STEPS TO END THE AIDS EPIDEMIC AND VIOLENCE AGAINST WOMEN

1

Government leaders speak out against violence and ensure laws that support women's rights as human rights

2

Link the HIV response to our sexual and reproductive rights

3

Increase capacity of service providers

4

Galvanize and empower communities of women living with HIV

5

Collect better data, and monitor spending and results

Conclusions and Recommendations

Based on the experience and successes of the AIDS response

- Multi-sectoral responses are effective and critical to address public health and social issues with complex social , cultural, economic and political drivers and which affects which impact every aspect of life and society
- People and communities must be at the center and participate at all aspect of the multi-sectoral response and must be empowered to do so.

Some Conclusions

Multi-sectoral approach is not just a principle but also is a skill and must be properly implemented and managed

- Define roles and responsibilities, based on the mandate and comparative advantage of each player/stakeholder. Be dynamic, flexible, strategic and coordinated;
- Smart partnerships with relevant sectors (Enablers, synergies, integration)
- Public Health & Evidence & Human Rights principles and approaches must reinforce each other
- The coordination and governance of multi-sectoral response and ensuring mutual accountability is critical
- The health sector has a critical role as the main powerhouse, implementer, duty bear, technical and human resource reservoir ... however must be kept accountable

Post-2015 agenda

Post 2015

- 🚫 What will it take to end AIDS? (unfinished business)
- 🚫 The AIDS response has been a pathfinder for identifying and addressing underlying structural and social drivers of the epidemic.
- 🚫 Building on this experience the Global Health response post 2015 can and should be a major force and a major public policy instrument for Social Justice
- 🚫 How should the global health and AIDS architecture be modernized for the post-2015 development agenda (“3 institutions”)?
- 🚫 Use recommendations of the UNAIDS-Lancet Post-2015 Commission (“Defeating AIDS, Advancing Global health”)
 - 🚫 Co-chaired by Peter Piot, report expected in Jan 2015

Zero new HIV infections.
Zero discrimination.
Zero AIDS-related deaths.



Defeating **AIDS**
Advancing global health
.....
THE UNAIDS AND LANCET COMMISSION



Addressing Ebola

“A multi-sectoral approach is the best way to end Ebola. Government and civil society should work together.”

Michel Sidibé, UNAIDS Executive Director on a joint visit to Mali

- The Executive Director of UNAIDS, Michel Sidibé was accompanied by the Director-General of the World Health Organization, Margaret Chan, on a recent visit to Mali to support the country in its efforts to curb the spread of Ebola and translate lessons learned from the AIDS epidemic into action on the ground. Mark Dybul, Executive Director of the Global Fund to Fight AIDS, Tuberculosis and Malaria, and Jean-François Delfraissy, French coordinator of the international and national Ebola response, joined the high-level visit.
- Together with the Malian Minister of Health, the delegation visited an Ebola treatment centre in Bamako run by Médecins Sans Frontières, where an Ebola patient is being treated. They later met with civil society representatives, religious leaders and health workers.

Recommendations for Belgian Cooperation

- Build on the lessons learned from the multi-sectoral AIDS response at global, national and community level for SRHR and health
- Put people and communities firmly at the centre of a multi-sectoral SRHR response.
- Empower vulnerable/marginalised populations to fully participate
- Invest in the governance of the multi-sectoral response, build capacity of health sector to manage multi-sectoral mechanisms and processes.
- Advocate for a bigger role & impact of the global health response as platform & actor for global social justice
- Develop guidance for smart integration of HIV/AIDS and SRHR
 - Full integration of SRHR & HIV/AIDS whenever possible, relevant, effective and efficient
 - HIV sensitive SRHR policies & programmes
 - SRHR sensitive HIV policies & programmes

Q&A

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