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New York

President: Mr. Eliasson . . . . . (Sweden)

The meeting was called to order at 4.20 p.m.

Agenda item 45 (*continued*)

Follow-up to the outcome of the twenty-sixth special session: implementation of the Declaration of Commitment on HIV/AIDS: closing of the meeting of the General Assembly on the comprehensive review on HIV/AIDS

Report of the Secretary-General (A/60/736)

Note by the Secretary-General (A/60/737)

The President: Before I start the proceedings, let me thank everyone for their active participation in this unique, very special meeting. We feel a certain energy in the halls and the corridors. Indeed I hope that this energy is channelled in the right direction, namely, in the direction of dealing with one of the greatest threats, but also one of the greatest challenges, that we are facing in today's world: the fight against HIV and AIDS. Participants, I thank you for your commitment. I thank you for your engagement. I count on your assistance in achieving the best possible results from this meeting.

Before proceeding to the comprehensive review, I would like to consult the Assembly with regard to the proposal that was presented to members at the 83rd plenary meeting, held on 30 May 2006. Since there has been no objection, may I take it that it is the wish of the General Assembly that, in order to accommodate the list of speakers for the High-level Meeting — which is a record number — on Friday, 2 June, and to facilitate the participation of all speakers inscribed on the list, the High-level Meeting would be split and continued in two parallel segments after the opening statements by the President of the General Assembly and the Secretary-General, statements by the Executive Director of the Joint United Nations Programme on HIV/AIDS and the Executive Director of the Global Fund to Fight AIDS, Tuberculosis and Malaria, and also statements, of course, made by heads of State or Government, Deputy Prime Ministers former Prime Ministers.

Furthermore, the two parallel segments would form an integral part of the High-level Meeting and would take place simultaneously in two different conference rooms with the remaining speakers on the list being assigned to one of the two segments on an alternating basis. Moreover, the two segments would be of equal status, with full conference services and interpretation, and the speakers in the two segments would be invited to speak from a podium. All delegations would be invited to be present at both meetings.

The High-level Meeting would reconvene in the General Assembly Hall for the adoption of the political declaration and for the closing statement by the President of the General Assembly after all the speakers have been heard. This arrangement would in no way create a precedent for future meetings of the General Assembly.

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It was so decided.

The President: Parallel segments A and B will therefore be held in Conference Rooms 2 and 3, respectively. Copies of the provisional list of speakers, number 2, for tomorrow's meeting are now being distributed. The provisional list will also be available from the Secretariat.

The General Assembly will now continue its comprehensive review of the progress achieved in realizing the targets set out in the Declaration of Commitment on HIV/AIDS (resolution S-26/2), in accordance with General Assembly resolution 60/224 of 23 December 2005. We shall hear summaries of the discussions by the Chairpersons of the informal interactive civil society hearing and the five round tables.

In accordance with the decision taken by the General Assembly at its 83rd plenary meeting, on 30 May 2006, we shall also hear summaries by the Rapporteurs of the five panel discussions. I would like to remind the Chairpersons and the Rapporteurs that their summaries are limited to 10 minutes, the same amount of time that I hope that my own summary of the interactive civil society hearing yesterday will require.

Yesterday, I had the privilege of chairing the interactive civil society hearing. It was very well attended, vibrant and at times even passionate, and all the time compassionate. The very real experiences of people from a great diversity of backgrounds were brought into the room. All of us who were there learned much, about both the reality of HIV and AIDS and the actions we now need to take.

I shall now make an attempt to summarize — and I emphasize the word "summarize" — the views we heard around a number of themes which emerged, based on the profuse notes from this hearing.

On the matter of commitments and accountability, there was a clear call for an acknowledgement that many of the targets in the 2001 Declaration of Commitment have not been met. We also clearly heard that people living with HIV and AIDS and in vulnerable groups must be recognized as partners and as a central component of the more urgent and more comprehensive response to the pandemic. They must hold their Governments to account for their performance against their time-bound commitments. Their involvement is essential to success. It cannot be seen as an optional extra. The hearing also dealt with the needs of marginalized and vulnerable groups.

We were reminded that the world has examples of strategies that are feasible and that work. We were asked to ensure access to sterile injection equipment, to condoms and to methadone. We were asked to ensure that drug users and marginalized populations have equitable access to prevention, medical care and antiretroviral treatment by establishing country and global targets. We were asked to support the meaningful involvement of drug users at all levels of planning and policy. And we were asked to end the random imprisonment, criminalization and human rights violations of drug users and sex workers.

On the impact of AIDS on children, there was a strong view expressed by civil society that there had been a lack of commitment and that we had failed our children and thereby jeopardized our future. To address that, there was a clear call for accessible and sustainable healthcare services that are both youth-friendly and HIV-positive-friendly. The need for social protection systems to support orphans and vulnerable children and their families and caregivers was emphasized, as was the need to provide legal frameworks for children to enable them to access services and to protect their inheritance rights in cases where their parents have been killed by the pandemic. We were reminded of the serious need to end violence against children. The point was powerfully made that the best way of helping children whose parents are infected is to keep their parents alive.

When I opened these three days of meetings yesterday and introduced Khensani Mavasa (see A/60/PV.84), I drew attention to the need to respond to the feminization of the epidemic. That was a recurring theme in the hearings. We heard that, while the spread of HIV is affected by poverty, caste, class, race and sexual orientation, gender inequality places the burden of the epidemic on women. It was made clear that HIV/AIDS targets those who cannot negotiate safer sex — women who have been trafficked, women in situations of conflict, women and girls in custody, sexually abused women and girls, transgendered people and all those who live a marginal existence on the fringes of society.

Civil society therefore called for comprehensive sexual and reproductive health services, universal

access to subsidized condoms and female control and prevention technologies, such as microbicides, and comprehensive sexuality education. There was a clear call for all women to have access to treatment without discrimination.

On sexual and reproductive health and rights, there was a strong emphasis on the outcomes of the International Conference on Population and Development and a reminder that HIV/AIDS and sexual and reproductive health are inextricably linked and must go hand in hand.

On the role of religion, we heard an acknowledgment from an HIV-positive religious leader of the difficulties that the faith community has had in accepting people living with HIV. There was an openness to acknowledge past mistakes and to play a leading role in moving towards inclusive communities in which stigma and discrimination could be truly overcome.

On human rights, there was a call for States to enact laws and policies which protect the human rights of all people and to invest in the human rights of people living with HIV.

On resources for health services, speakers drew our attention to the consultations which had taken place on universal access. There was strong endorsement of the call for Governments to commit the $20 billion to $23 billion that is needed annually by 2010 to support rapidly scaled-up AIDS responses and to do so through flexible and sustainable mechanisms.

We were reminded that universal access could not be achieved without ensuring the recruitment of health workers, ensuring adequate training, adopting alternative ways of staffing health services and tackling the brain drain.

From the private sector, we heard evidence that it is in the economic interest of companies to provide antiretrovirals to their staff. We also heard about the importance of placing human rights at the centre of the workplace AIDS response. And we heard a call to take successes in treatment in the workplace into the communities around them.

On the question of trade, there was a call to Member States to institute a moratorium on any new bilateral or regional trade agreements which include provisions involving intellectual property rights and medicines. We were asked to refrain from implementing any provisions in such agreements which are contrary to the 2001 Doha Declaration on Trade-Related Aspects of Intellectual Property Rights (TRIPS) and Public Health.

Civil society also called on Governments to make maximum use of the flexibilities in the TRIPS Agreement and to issue compulsory licenses where there are problems of access due to patent restrictions.

Lastly, on research and development, we heard an assessment that the current global system for supporting innovation in new medicines and other health technologies is inadequate. Civil society called for increased sustained funding for AIDS vaccine and microbicide research and development, and welcomed the World Health Assembly resolution adopted on 27 May which called on Governments to act to boost innovative research and the development of medicines.

I believe that I have fairly summarized the very rich interactive discussion between Member States and civil society. Now, the main task for us is to finalize work, not least on the political declaration. I call on all members to ensure that we have a strong outcome which is commensurate with the scale of the human tragedy, as well as the scale of the political challenge that they will now face.

I now give the floor to the Chairman of round table 1, His Excellency The Honourable Denzil Douglas, Prime Minister of Saint Kitts and Nevis.

Mr. Douglas (Saint Kitts and Nevis), Chairperson of round table 1: Let me first thank those who participated in the discussion in round table 1. As was indicated in the report of the Secretary-General entitled “Declaration of Commitment of HIV/AIDS five years later” (A/60/736), there was broad consensus among round table 1 participants, first, that there is a strong level of commitment; secondly, that much work has been done; and, thirdly, that much progress has been made since the 2001 endorsement of the Declaration of Commitment on HIV/AIDS.

Even as greater numbers join the response to HIV/AIDS, the situation remains serious in populations. It remains serious in countries and regions throughout the entire world. The progress has had some impact and provides glimmers of hope. Yet the situation is still very grave. Serious setbacks continue, and there is concern about reaching targets of universal

access — universal access to prevention, treatment, care and support over the next five years.

The discussion in the round table addressed a number of questions that had been posed. First, how do we expand access to treatment and access to prevention information and services? Secondly, how do we ensure that the world's young people translate information into knowledge and knowledge into behaviour change? Thirdly, how do we reduce the stigma and discrimination borne by those living with HIV/AIDS or suspected of having HIV? Fourthly, how do we overcome financial bottlenecks? And fifthly, how do we fully engage all partners in the response?

Several key messages can be drawn from the discussions. The first message is that national plans are the foundation for reaching our targets. Solid strategic national HIV/AIDS plans begin with the first element of the "three ones": one coordinated national body that includes all stakeholders from Government, civil society and the private sector and, most important, people living with HIV/AIDS. National strategic plans must be comprehensive within and across prevention, treatment and care, including increased access to condoms, sexual and reproductive health services and also, of course, ensuring youth-friendly environments. Plans should also reflect the national characteristics of the epidemic and must build on positive cultural, faith-based and social practices. Effective and concrete action can be taken locally. The imperative is that all stakeholders must be able to rally around one single national programme and share in the responsibility for its development and implementation.

The second message is that more sustainable financing is absolutely essential. In many developing countries, the political will for action is there, but access to funds differs. The current funding eligibility criteria, which are based solely on gross domestic product (GDP) and prevalence, require urgent — and I stress, urgent — revision. These criteria alone do not take into account the high debt-to-GDP ratio that has eroded very many economies, which is a fact of great concern and a major setback to achieving these goals.

Serious concerns were also expressed about the lack of ability on the part of poor countries to sustain systems already put in place, especially those that provide prevention services. Countries that have graduated out of grant programmes often experience the setback of not being able to advance as quickly as they wished, including to the breaking of the barriers of stigma, discrimination and the gender problems which deprive our world's women of the equality that they so rightly deserve in this, our modern world.

Waiting until a country is considered to have high prevalence means addressing a more complicated epidemic. One lesson learned from countries in a generalized epidemic related to the failure to act early, when prevalence was very low. Support was expressed for simplification and harmonization of donor resources and reporting, the elimination of conditionalities on the spending of resources, a focus on specific country needs within the response and the strengthening of absorptive capacities, especially of small developing countries, which we believe could accelerate the response. We must continue to seek ways to strengthen systems and processes, to build capacities and to deal with the bureaucracies that we experience. We must learn from the examples provided by developed countries that are supporting work in developing countries on the basis of the requests and needs of those countries. Donor support, we stress, must be apolitical.

The third message relates to the need to strengthen and maintain health care systems. Developing countries have serious concerns about how to ensure the continued provision of treatment and prevention services. For instance, the lack of skilled personnel in many developing countries could be resolved by providing more and more relevant training, coupled with efforts to retain trained personnel, who frequently migrate to developed countries in search of better jobs. Developed countries have an obligation to recruit — but to recruit responsibly.

The fourth message is related to the third: there is a need for radical changes in care and treatment. Particular note was made of the need to increase access to antiretrovirals and the need to move away from a fragmented approach and towards an integrated approach, thus providing a comprehensive package of prevention and care services, including, of course, voluntary counselling and testing and programmes that address tuberculosis-HIV/AIDS co-infections.

The fifth message is that there must be greater emphasis on reducing stigma and discrimination and on respect for human rights. Universal access will not be possible, I stress, if stigma and discrimination remain. Our discussions brought to the fore that the increasing

invisibility of those who are at high risk of infection and the inability to openly mention those groups by name — such as commercial sex workers, drug users and men who have sex with men — in fact increase the stigma and discrimination that they already face. The need to be visible was stressed in our discussions, as well as the need to become involved and included in our programmes.

The sixth message is that, while there is a need to reintensify prevention. This must not be seen as a new programme. Successful evidence-based prevention programmes are well known. For example, the importance of education, including curricula in schools, life skills and reaching young people — especially young girls out of school — with information, skills and services must be underscored. New prevention technologies must be developed, and such development must be urgently supported. What is missing is better costing and better prevention, with specific and dedicated budgets within national programmes for prevention. What is also often missing is data collection and strength of indicators that are present for treatment. What also continues to be missing is the engagement of certain powerful partners such as the business community. This, of course, includes using workplace programmes as part of a social vaccine and businesses harnessing their strength in media marketing and promotion to support behaviour change. Business and the media can help to translate information into knowledge and knowledge into behaviour change through proper marketing strategies. These skills already reside in the business community: the know-how to reach the people of concern with effective, targeted messages. Business coalitions, therefore, must now be brought on board as partners.

The seventh message is that if we are not talking about young people, we are not talking about this epidemic at all. There are 1 billion young people who are entering their sexual and reproductive lives. They need information, they need skills, they need choice and they need protection of their rights. They need to be involved. The presence of those in this Hall as representatives at this review, therefore, bodes well for our future.

The eighth and final message is that HIV/AIDS is a lifelong problem and therefore commitment must not and cannot waver. Commitment must now translate into action — action which employs equitable partnerships, action which builds on shared successes, and action which ensures a path towards universal access to prevention, treatment, care and support.

The President: I would remind the Chairpersons to limit their comments and summaries to 10 minutes.

I now give the floor to Ms. Annmaree O'Keeffe, Ambassador for HIV/AIDS for Australia and Chairperson of round table 2.

Ms. O'Keeffe (Australia), Chairperson of round table 2: I, too, want to thank very much those who participated in round table 2, held yesterday afternoon. I think we all found that it was lively and a true exchange of ideas and thoughts — very constructive ones. I apologize now if my summary fails to mention all the wonderful ideas that came out, but I want to reassure the Assembly that, for the sake of brevity, I am sticking very much with the headlines that came through. Indeed, all contributed very significantly.

As we have heard already, there were four key questions — four key themes — which the round table aimed to discuss. Allow me to reiterate them. First, what needs to be done to re-intensify prevention programmes? Secondly, what can be done to translate information into knowledge and knowledge into behaviour change? Thirdly, what financial bottlenecks are our countries experiencing, and how can they be overcome? And fourthly, how can Governments, bilateral and multilateral organizations further engage civil society, including representatives of people living with HIV?

Many of the participants in round table 2 noted that prevention had taken a back seat in response to HIV/AIDS. The disease cannot be contained or reversed without increased emphasis on prevention. That said, a comprehensive, multi-pronged approach that integrates prevention programmes and treatment cannot be devised in a generalized manner. Prevention, testing and treatment need to be implemented together to promote the behaviour and societal changes necessary to fight HIV/AIDS. There are no one-size-fits-all programmes. A holistic, multi-pronged approach — one that involves and targets the vulnerable groups — is crucial to achieving results.

A key ingredient in the reintensified programmes is involvement by leaders and people living with HIV/AIDS. The education sector, too, was identified as critical to prevention efforts. Just as health systems

need strengthening, so do education systems if teachers and students are to be part of a comprehensive response.

Addressing the whole issue of the feminization of the epidemic in a comprehensive way is essential for prevention to succeed. I shall say more about that shortly.

Young people, it was recognized, are the key to fighting HIV/AIDS, but understanding how to convert knowledge into behaviour change is difficult but essential. Information alone is not sufficient to change behaviour. Affirmation and empowerment are the critical tools. Education and the dissemination of knowledge must be scaled up, particularly for schoolchildren.

Overall, the round table found that services for youth are inadequate. Young people need support in order to make their own choices. Donors should acknowledge that fact and pledge their continued support.

It was essential, too, to discuss sexual and reproductive health as it relates to young people. Children and young people, particularly young girls, need early education to be better equipped to understand the risks of HIV/AIDS. Support for orphan children must be critically examined to ascertain and uncover what their future holds.

In the area of financial bottlenecks, it was recognized that, while resources were available and have indeed increased, what was absolutely critical was the predictability and sustainability of the funding. To reach key goals in the upcoming years, various sources of financing should be tapped through domestic resource mobilization, contributions from traditional and emerging donors, innovative financing mechanisms, and private contributions through business coalitions and public-private partnerships.

Local governments and communities, too, were encouraged to increase their own resources to assist the ultimate goal of sustainability. But recent financing bottlenecks in part relate to weak absorptive capacity and weak health systems. Payment procedures, too, were identified as needing simplification to speed up access to needed resources.

Some participants mentioned the lack of capacity to apply for Global Fund resources and called for assistance in that area. Participants stressed that external support must be aligned with national plans and that donors must harmonize their assistance for greater impact. Accountability and performance were key, and there should be zero tolerance for any misuse of funds.

With respect to engaging civil society, it was recognized that civil society plays and will continue to play a major role in the response to the disease. Participants called for more engagement with civil society in a climate of constructive partnership and trust. Civil society partnerships must be strong, vibrant and transparent for mutual respect.

Particularly important is the involvement of people living with HIV/AIDS, in particular to ensure successful prevention programmes. People living with HIV/AIDS must be involved when decisions are made at the policy level and when national plans and strategies are being elaborated. Such inclusion of vulnerable groups makes interventions more relevant, effective and sustainable.

A problem mentioned repeatedly during the round table was that of ensuring sustained financing for civil society organizations. Scaling up is not only about financing but also about human resources. Community volunteers were identified as a great resource that is not currently tapped and were not included in the HIV/AIDS response.

It was also noted that ministries of health often did not have the capacity to engage with a wide range of partners. Assistance should be considered to help build the capacity of those ministries in dealing effectively with civil society.

Participants also mentioned the essential role of civil society in monitoring progress, and the recent launch of the African Monitor was cited as an independent body worthy of mention. Civil society monitoring promotes accountability to make sure that money reaches the most vulnerable groups.

Three key themes recurred throughout our discussion of the four issues. It was repeatedly recognized that central to any successful response was the recognition and empowerment of women and girls. The feminization of AIDS continues at an alarming rate, fuelled by widespread violence against women and lack of access to sexual and reproductive health services, as well as the prevailing social and economic inequities.

Women living with HIV/AIDS need to be given seats at key decision-making meetings, particularly with respect to financing issues for women. They should be acknowledged as a vulnerable group, with measurements established to monitor progress on those issues. Gender-responsive budgeting for investments and expenditures was considered essential.

Another key issue that came through repeatedly was the need to address naivety and to deal with taboos of all things sexual and related to the spread of HIV/AIDS. We must be wary of the denial in order to have interventions which address marginalized, high-risk groups, such as men having sex with men and injecting drug users.

The third very important issue running through the entire discussion was human rights. Human rights are the cornerstone of HIV prevention and the mitigation of responses for vulnerable groups. Civil society is the best guarantee for the protection of human and women's rights.

As I said at the beginning, this is merely a summary of a very interesting debate and exchange of ideas that we had yesterday, and again, I wish to thank all participants.

The President: I now give the floor to the Chairperson of round table 3, The Honourable Silvia Masebo, Minister of Health of the Republic of Zambia.

Ms. Masebo (Zambia), Chairperson of round table 3: I want to start by thanking you, Sir, for the opportunity given to Zambia to chair the round table 3 discussion.

I also want to thank all those who participated in a very lively debate and assure the Assembly that the summary I will read out is exactly what we said yesterday. We in round table 3 actually read the statement and adopted it, so nothing has been added or subtracted — meaning that all the ideas have been captured, as you yourself put it yesterday, Sir.

Round table 3 reaffirmed the findings of the Secretary-General's reports that progress has been achieved in major areas of the HIV and AIDS response. However, many challenges still remain. The strong financial and political commitment that has been built since 2001 must now be translated into concrete action to reverse the epidemic. The following summary of deliberations in round table 3 highlights the way forward in addressing the challenges identified in the Secretary-General's report.

In addressing what needs to be done to intensify prevention, participants concluded that it is clear that prevention efforts must be strengthened. That requires scaling up simultaneously HIV prevention, treatment, care and support programmes. There is no single AIDS epidemic nor is there a one-size-fits-all solution. Therefore, innovative programmes and messages are needed that are accessible to all. There is a particular need to implement targeted programmes for young people, especially appropriate sex education beginning in the early stages of schooling. We must also continue to strengthen programmatic prevention for vulnerable groups — including injecting drug users, sex workers, and men who have sex with men — and continue to promote condom use.

There must be no dichotomy between prevention and treatment, and we need to promote research for vaccines, as well as female-controlled prevention methods, including microbicides. We must also intensify prevention actions in low-prevalence countries based on lessons learned from high-prevalence countries.

Respect for human rights, the reduction of stigma and discrimination, as well as the achievement of gender equality are essential for creating an environment in which prevention programmes can be implemented more effectively and scaled up. Scaling up cannot be achieved without safe spaces that are free from stigma and discrimination for vulnerable groups and people living with HIV.

Reinforcing the implementation of existing mechanisms, such as the Convention on the Elimination of All Forms of Discrimination Against Women, to eliminate discrimination against women and girls is crucial to intensifying prevention programmes.

The promotion of youth-friendly and women-friendly services, including sexual and reproductive health services, is fundamental, and ensuring a special focus on making HIV information and education widely available to young people remains a priority. Enhanced efforts must also be made to reach the most vulnerable groups with a special focus on promoting their rights.

Many of the strategies discussed in the round table are captured in the policy position paper on intensifying HIV prevention issued by the Joint United Nations Programme on HIV/AIDS. The prevention policy paper and action plan provide excellent guidance for countries to intensify prevention programmes.

On addressing what needs to be done to translate information into knowledge and knowledge into behaviour change, participants noted that, despite the high level of awareness and knowledge of HIV/AIDS, people often engage in behaviours that are risky to survival, which increase the risk of infection and continue to fuel the epidemic. Indeed, there is a correlation between individual behaviour and collective attitudes, as well as socio-cultural factors that mould the environments within which we live.

Comprehensive responses that address the underlying factors driving the epidemic, as well as the structural factors that increase vulnerability to HIV, are essential. That includes addressing poverty and discrimination against women and vulnerable populations.

Young people, particularly young women, need to be reached at an early age with appropriate messages, information and sexual education, including through school curriculums, to empower them. That must involve the promotion of and respect for human rights and gender equality.

In analysing the financial bottlenecks that countries are experiencing and how to overcome them, participants stressed that the “three ones” principles must be systematically applied to avoid inefficient duplication and the creation of parallel systems. Those principles can enhance efficiency, minimize transaction costs and contribute to greater accountability and the transparent use of resources.

Human resources capacities must be strengthened along with health infrastructure and systems, and the HIV response must be effectively integrated into health systems and tuberculosis and reproductive health programmes reinforced.

While resources for addressing AIDS have increased substantially, they have yet to reach an appropriate level to reverse the epidemic. Domestic budgets for health need to be increased and resources must reach their intended beneficiaries.

We have now been living with this epidemic for 25 years, and unfortunately we will have to live with it for years to come. Funding for the AIDS response is a long-term commitment and should therefore be predictable and sustainable to make a real difference.

How can Governments, bilateral and multilateral organizations further engage civil society, including representatives of people living with HIV?

It has been recognized that civil society has been at the forefront of the response, and that it has contributed greatly to the success achieved thus far. Governments and the international community must engage civil society as a true partner in the response, and must ensure that people living with AIDS are actively involved in all aspects of national responses. For the response to be effective, all stakeholders must be involved.

In that context, it is important to enhance the capacity of civil society and to empower organizations and networks of people living with HIV, particularly women’s organizations. Governments, civil society and cooperating partners must increase transparency and accountability in order to have a more effective and meaningful partnership.

In our concluding deliberations, participants questioned whether we had made progress since 2001. The answer was definitely yes. The other question was whether we were satisfied with the current status of the response. The answer was an emphatic no. That leads us to conclude that there is a long way to go. While participants strongly supported and reaffirmed the 2001 Declaration of Commitment, they expressed concern, and hoped that we would reach a stronger and renewed political commitment in 2006. May our renewed commitment in 2006 help us to meet the challenges we face, and accelerate the response.

The President: Before I give the floor to the next speaker, I would like to inform the Assembly that, due to other pressing duties, I will soon yield the Chair to my trusted friend, and Vice-President of the General Assembly, His Excellency Mr. Cheick Sidi Diarra, Permanent Representative of Mali.

I now give the floor to Ms. Auna Marzec-Boguslawska, Chairperson of round table 4 and Director of the National AIDS Centre of Poland.

Ms. Marzec-Boguslawska (Poland), Chairperson of round table 4: As the Chairperson of round table 4,

let me present a brief summary of the discussion we had this morning.

Mr. Diarra (Mali), Vice-President, took the Chair.

Participants generally agreed that since 2001 significant progress had been made; however, we still have a long way to go before achieving the targets set out in the Declaration of Commitment (resolution S-26/2). Let me now quickly summarize the six most important issues raised during the discussion.

First, comprehensive and holistic approaches are the most effective way forward. Prevention, treatment, care and support in the context of universal access cannot be separated and must go hand in hand. Increased access to antiretroviral treatment, including paediatric antiretroviral drugs, must not lead to a waning of prevention efforts. All people, particularly young ones, have the right to the full package of education, information and services — including voluntary counselling and testing, which have proven to be effective — that are necessary to reduce their vulnerability to HIV and AIDS. The response to HIV and AIDS must be firmly grounded in the promotion, protection and fulfilment of human rights.

The capacity of health, education and social systems must be strengthened and sustained. That will provide the basis for accelerated progress and will ensure that actions are sustained and of sufficient scale to have a meaningful and lasting impact.

Adequate allocation of financial resources is a core element of the effectiveness of our actions.

All countries need vibrant responses to HIV and AIDS, regardless of the stage of the epidemic they are experiencing. Those responses must be tailored to specific cultural contexts and take into account poverty, social marginalization and exclusion.

The need for stronger human capacity remains a challenge and a key priority.

Participants also stressed that political will and commitment at all levels are a key element of strong national responses. That should be reflected in appropriate laws, national policies, goals and targets, efforts to address stigma and discrimination and sustained and increased financial and technical support.

The importance of leadership at the global, regional and country levels was also underscored. A bold renewal and strengthening of commitment on HIV and AIDS is vital.

It was stressed that coordination and strengthened partnerships are essential. They should be multisectoral — extending across the various government agencies and sectors — while actively engaging civil society organizations, and in particular people living with HIV and AIDS and those working with vulnerable populations. Moreover, the focus should be on women, girls and young people.

Bringing together donors and international partners at the international and country levels contributes to providing a more effective response to the pandemic. In that context, the need for the full implementation of the “three ones” principles was highlighted.

Education, including sexual education, remains a key part of effective progress on HIV and AIDS, and will be most effective when it is rights-based, culturally appropriate, available at an early age, gender-responsive and provided both in and outside of school. Good quality education is what will enable knowledge to be translated into the behaviour changes necessary to make progress against the epidemic, and particularly to reduce the vulnerability of women and girls.

Finally, focused attention to address the needs of particularly vulnerable populations is a prerequisite to turning the tide of the epidemic. That includes expanding access to services and support with, and for, sex workers, men who have sex with men and injecting drug users. In that connection, several delegations stressed the importance of harm-reduction programmes and the effectiveness of substitution therapy. Intensifying efforts to address the needs of victims of conflict and war, displaced persons and migrant populations is also crucial. Reducing the vulnerability of key populations includes the need for men to behave responsibly, such as by using condoms and respecting women as equals.

That brief summary reflects the most important topics raised today, but does not constitute an exhaustive list. Let me take this opportunity once again to cordially thank all the participants in round table 4 for their involvement.

The Acting President (*spoke in French*): I now give the floor to the Chairperson of round table 5, Mr. Oscar Fernandes, Minister of State of India.

Mr. Fernandes (India), Chairperson of round table 5: At round table 5 we had a very lively discussion, and the following key points were raised. Participants reiterated the need for strong political will and leadership, and provided a number of examples of how that had been strengthened in the past five years. However, a number of participants forcefully expressed the need for a strong declaration based on the 2001 Declaration of Commitment, clearly spelling out the need for an intensified response to HIV/AIDS and a clear, visionary way forward with ambitious targets.

Participants acknowledged the significantly greater availability of resources to address HIV and AIDS. However, some middle-income countries pointed out the difficulty of accessing funds because of often not being eligible for global HIV/AIDS resources. Often, interventions get hijacked by donors' agendas and priorities.

It was also noted that funding needed to be sustainable and predictable in order to make the money work. In that connection, the private sector and partnership with other groups, such as trade unions, may play an important role.

One recurring theme was the need to scale up evidence-based prevention. Countries pointed out that there are a number of obstacles to scaling up, including a lack of general access to care and political commitment, which is often other than evidence-based. However, reports pointed out that faith-based organizations have an important role to play.

Countries reiterated that prevention and treatment represent a continuum, and that interventions need to be holistic and comprehensive.

Stigma and discrimination, violations of human rights and gender inequality were highlighted as key challenges impeding the response to HIV/AIDS. Vulnerable groups — such as injecting drug users, sex workers and men who have sex with men — are often excluded from national responses. Vulnerable groups are a part of each society and Governments need to acknowledge that fact. Vulnerable populations should be part of the solution, rather than part of the problem. Various speakers indicated that excluding mention of vulnerable populations in the political declaration would not make their problems disappear.

It is no accident that women and children have higher infection rates. Women should not be controlled, but should have control over their own lives. New prevention tools controlled by women should be made available to them.

There should be more investment in research and prevention technologies.

It should no longer be acceptable that children are born with HIV. The lack of paediatric care and appropriate antiretroviral therapies for children, as well as the vulnerability of AIDS orphans, were mentioned frequently.

Many participants emphasized the need for the introduction of culturally appropriate sex education for young people.

A number of countries described the serious HIV/AIDS epidemic among drug-injecting populations, as well as how they address it. Harm-reduction measures, including substitution treatments and needle and syringe programmes, feature as prominent interventions of a comprehensive approach.

Lack of human resources in many countries was mentioned as an impediment to scaling up prevention, treatment and care. The migration of skilled health workers from developing to developed countries was seen as a major obstacle in the response. A number of examples to alleviate this problem were given, such as developing partnerships with civil society and with organizations of people living with HIV/AIDS. Such organizations have been instrumental in moving forward the response to HIV and AIDS.

Before concluding, I would like to thank all the participants in the discussion we held at round table 5.

The Acting President (*spoke in French*): We have just heard the last statement concerning the round tables.

I now give the floor to the Rapporteur of panel 1, "Breaking the cycle of infection for sustainable AIDS responses", Mr. Wu Zunyou, of China's National Centre for AIDS, and the Control and prevention of Sexually Transmitted Diseases.

Mr. Wu Zunyou (China), Chairperson of panel 1: On behalf of panel 1, I shall present the

Assembly with a summary of the discussion on the subject of breaking the cycle of infection. Our panellists and other participants included a cross-section of countries, representing Governments, United Nations agencies, the private sector and civil society.

AIDS continues to be an emergency. While we must act quickly to reach our targets and avoid having more people die, we must also make sustainable efforts. As the Assembly has already heard, we have reached a crossroads. Governments, donors and individuals must decide whether we will be part of the problem or part of the solution. Specifically, we must realize the following points.

First, breaking the cycle of infection needs to address the entire cycle. Prevention, treatment, care and support must be brought together into a comprehensive and integrated programme where the variety of needs is addressed simultaneously.

Secondly, the impact of HIV/AIDS is a threat to all sectors of society. A multisectoral response is required. Treating HIV/AIDS primarily as a biomedical issue is inadequate. Education, food and nutrition and income-generating activities were mentioned as essential inputs needed to combat HIV/AIDS.

Thirdly, evidence-based programmes are critical to stem the spread of HIV. Effective prevention programmes need to understand and address the specific behavioural and cultural issues of various HIV-AIDS-affected groups and populations, especially vulnerable groups such as men who have sex with men, commercial sex workers, injecting drug users, people in prison and women. That requires frank talk about difficult subjects. An open dialogue about sex, sexuality, gender and drug use is essential. Related to that, voluntary counselling and testing must be made more available and accessible, and follow-up medical services should be routinely provided.

Fourthly, women and youth are disproportionately affected by the epidemic and require special attention. They need comprehensive information on sex education and reproductive health and access to counselling and health services. Efforts to improve gender equity must also include boys and men.

Fifthly, twenty-five years into the epidemic, stigma is still a problem. We must make much greater strides to eliminate stigma and protect human rights. Legislation plays an important role and should be supported by political will and community campaigns.

Finally, all sectors and groups have a role to play in the response, especially civil society groups, people living with HIV/AIDS and the private sector.

In closing, it must be reiterated that the epidemic is spreading every minute. We need action today. We need action now.

The Acting President (*spoke in French*): I now give the floor to the Rapporteur of panel 2, “Overcoming health worker shortages and other health systems and social sector constraints to the movement towards universal access to treatment”, Mrs. Sigrun Møgedal, AIDS Ambassador of Norway.

Mrs. Møgedal (Norway), Rapporteur of panel 2: The work of panel 2 left us in no doubt that there is a crisis in the health workforce and that this crisis severely limits our ability to scale up the AIDS response. There are severe and fatal shortages. Health workers are exhausted. They need to be paid, fully supported, connected, valued and respected; their voices need to be heard. Failure to react to this crisis in the past is costing lives today. Failure to act now will kill many more in the future.

We discussed with great concern how the fatal shortages and the maldistribution of health workers is associated with the “fatal flow” of health workers. That fatal flow goes from rural to urban, from public to private and from countries in desperate need to countries that offer better deals. The situation is not to be borne. Examples from the Caribbean and from Africa illustrated the scope of this crisis and demonstrated the urgency of addressing the situation.

An equally important message is that momentum is now gathering rapidly. The world is moving from neglect and denial of this issue to dialogue and consultation. We heard a number of examples that show what can be done. A number of countries and regions have started to implement comprehensive human resource plans. All of us must align in support of such efforts in that direction. We need converging steps between the industrialized and developing countries, and among the public sector, the private sector and civil society.

We also discussed potential strategies to address this. At the local level, relatively simple changes in policy and practice can make a big difference.

Simplified service delivery, alternative care models and standardized approaches to record-keeping, testing, treatment and clinical monitoring of patients, for example, were all seen as essential. We learned about sharing tasks across the full spectrum of health professionals, paraprofessionals and community health workers. Treatment literacy support and bringing in people who are themselves infected or affected to expand capacity and thus to improve the quality of the response are critical here.

Linkages between the AIDS sector and the health sector are still seen to be insufficient. But they are essential. There are still gaps to be filled between the "health world" and the "AIDS world". AIDS can drive a response that encompasses support for health and social systems beyond AIDS because of its momentum, the broad effort and the innovation it brings. There is no way to ensure a scale-up for the AIDS response in isolation, and AIDS can drive change.

The new Global Health Workforce Alliance provides a unique framework for accelerating action. It focuses on building country capacity, creating an enabling global environment and maintaining the visibility of the crisis.

There is unprecedented momentum for a massive scale-up in training, task shifting and more effective partnering. The imperative here is to mobilize all possible contributors, but to do so always within a nationally owned framework that pulls the different efforts together. New cadres at the community level need to be adequately supported and linked, not left alone. Here, we have something to learn from history: we were reminded in our discussion of the 1978 Declaration of Alma-Ata.

Country strategies need to link the actors in AIDS and the actors in health, both public and private, as well as professional associations and employers' organizations, organizing around a common action plan for training, retention and partnering.

Financing is always a major challenge. We heard very clearly that without decent pay for health workers we will not be able to move. We need to find home-grown, country-based solutions, align everyone across providers and identify the necessary steps to make them reality. In particular, we need to address the existing wage bill ceilings which currently are severely limiting action. The challenge of creating the needed fiscal space is real, but, as we heard, it can be managed as long as there are additional and predictable resources to invest. That means that North and South, donors and recipient countries need to work together to show that the resources are available, that they are being invested in the health workforce and that there is a will to set priorities accordingly.

We also heard that human resource plans must complement other national development and poverty reduction plans, along with striking an appropriate balance between the emergency responses that AIDS demands and the long-term investments in chronically neglected health and social systems. But investment in the health workforce is in itself a long-term undertaking, but it now has a clear emergency element. We cannot wait.

Someone said that we need to get traditional workers to play untraditional roles and that we need more untraditional workers taking on new roles. HIV/AIDS and other health services — for tuberculosis, reproductive and sexual health, for example — must be linked not only to reduce waste and duplication but to strengthen the human resource base of health systems as a whole.

Through workplace education and prevention programmes, we need to reduce the vulnerability of health workers to HIV infection. Health workers require and deserve treatment, care and support. Innovative approaches were suggested, including for learning-based activities for health professionals that can connect them more effectively with local communities and with each other; this can generate capacity. Because so many health workers are women, gender dimensions of human resources for health must also guide policy and programming.

We talked about what can be done in countries of need. Throughout the discussion, we heard the call for global approaches and solidarity. This is nowhere more true than for the challenges of health worker migration. There is a need for financial mechanisms and bilateral conventions to compensate for the brain drain from poor countries; this is beginning to feature prominently on the agenda of the international community. What we heard is that the North can and must do much more by reducing its dependency on foreign health workers, developing ethical codes of recruitment and monitoring progress transparently, through peer review. We talk about AIDS dependency, but here we also talk about the dependency on foreign health workers. We need to

be accountable to each other with regard to how all of this is linked together. Also suggested were twinning and exchange programmes with countries in the South.

To sum up, all development partners must do more to ensure efficient use of the resources we have and to mobilize more in order to ensure that technical assistance and the training that is provided always contribute to the building of local capacity. This is a special challenge to the external partners. They need to discover, recognize and respect local resources and expertise.

Speakers reported on disruptive competition for scarce human resources and its negative effects on already fragile health systems and, similarly, on situations where national and local organizations are marginalized by international non-governmental organizations. We cannot succeed without getting these partnerships to work. In many countries they do indeed work.

Many speakers emphasized that it is important to involve faith-based organizations, trade unions and employee associations in our efforts. In addition, there was also mention of the membership-based organizations in many communities which are not necessarily directly involved in AIDS work, such as the Red Cross. We cannot limit ourselves to specific organizations; we need to mobilize all possible ways to connect to local capacity.

We also talked about similar challenges in other sectors. But given the way the health sector is so specific to the scale-up, we have focused on it in this report.

When we look back in the years to come, let it be remembered that at this 2006 session we decided to take action. We acknowledge the severe constraints caused by health worker shortages. We commit ourselves to be bold and urgent in moving forward together in partnership, supporting country leadership for these critical actions in both North and South. We need to do it together.

The Acting President (*spoke in French*): I now give the floor to the Rapporteur of panel 3, "Ending the increased feminization of AIDS", Ms. Keesha Effs, National Youth Ambassador for Positive Living of Jamaica.

Ms. Effs (Jamaica), Rapporteur of panel 3: I am pleased to present a summary of the deliberations of panel 3, on ending the increased feminization of AIDS. I would like to share two powerful quotations from the panel's session. They added rich flavour to our discussion. The first was, "Why do we have to pretend that everything is okay when it is not? We are tired of lamenting; leaders need to know that we [women] are in pain and grief". The origin of this statement was panellist Lillian Mworeko of the International Community of Women Living with HIV/AIDS, Uganda.

The second quotation was, "We want empowerment before we get infected", spoken by a member of the audience, Anandi Yuvraj of the International HIV/AIDS Alliance, India.

Key issues and challenges were highlighted in the question "Why is the AIDS response not working for women and girls?" Answers included the following.

We have not taken sufficient account of the gender inequalities that drive the epidemic. Women and girls still have less access to education and know less about how to protect themselves from HIV/AIDS. There is no recognition that women living with HIV bear the double burden of the stigma of the disease and gender inequality. Girls and boys still do not have access to comprehensive sexuality education. Women do not have universal access to sexual and reproductive health services. Women lack economic opportunities. The human rights, including sexual and reproductive health rights, of women are not respected.

Gender-based violence is still the reality of many women's lives. Women are not equal partners in marriage or other relationships. Young girls and women are particularly vulnerable to early marriage, and to sex with older men. Women do not have an HIV prevention method that they can initiate and control. Men do not take sufficient responsibility for their behaviour towards women. Women are not meaningfully involved in the design of AIDS policies and programmes. Cultures and religions collude to keep women subordinate.

And the ultimate answer is that too little money is invested in AIDS responses that work for women and girls.

What is the way forward, through effective action and the solutions that have been recommended? More money than ever before is funding the response to AIDS, but far more needs to go into programmes that

benefit women and girls. Women and girls must be at the centre of AIDS programmes. Additionally, governance structures should abide by the "40-40" principle, where a minimum of 40 per cent of decision-makers are women. In particular, women must have equal numbers of seats at the tables where AIDS policies are designed and funded.

Gender expertise is as important as gender balance in shaping AIDS policy and programmes. Men in leadership positions — government at all levels, community, family and the private sector — must stand up, speak out and act in support of women's rights and gender equality. There is a need to invest in programmes that benefit women and girls, particularly sexual and reproductive health services and education, including comprehensive sexuality education. Women's rights — especially sexual and reproductive rights, property and inheritance rights, economic rights and the right to a life free of violence — must be secured.

It is crucial to close the funding gap for existing and new prevention technologies that will benefit women, such as the female condom, vaccines and microbicides. We must ensure comprehensive treatment and care, including sexual and reproductive health care, for HIV-positive women.

Men and boys need to take responsibility for transforming expectations of men's behaviours at home and in the wider world. All AIDS strategies should pass this test: they should be able to answer "yes" to the question: "Does this work for women?"

The private sector must take a role in addressing the feminization of the response.

When businesses talk, Governments listen: that position should be reaffirmed by businesses.

We must expand promising initiatives with faith-based organizations with a view to promoting women's rights.

In conclusion, the panellists were united in their call for a strong, progressive declaration which puts women and girls at the centre of the response to HIV/AIDS, not one that endorses the global game of jeopardy being played with the lives of women and girls.

The Acting President (*spoke in French*): I now give the floor to the Rapporteur of panel 4, "Sustainable and predictable financing for scaled-up AIDS responses", Mr. Omolou Falobi of Journalists Against AIDS of Nigeria.

Mr. Falobi (Nigeria), Rapporteur of panel 4: We had a very distinguished panel that discussed issues of sustainable and predictable financing for scaled-up AIDS responses. We had quite an interesting and exciting discussion, and came up with a number of thoughts, suggestions and recommendations. One of the first things that we noted was that, since the special session of the General Assembly that was held five years ago, there has been a dramatic increase in the resources available to deal with HIV/AIDS, both locally and internationally. There have also been new initiatives, such as the President's Emergency Plan for AIDS Relief and the World Bank's Multi-Country HIV/AIDS Programme, as well as the Global Fund to Fight AIDS, Tuberculosis and Malaria, which has given new impetus to the fight against those three diseases.

The price of medicines has also been drastically reduced; there has been a massive increase in the number of people on antiretroviral treatment; and the coordination of both national and international responses has been enhanced.

But, of course, we also agreed that there is a huge shortfall in terms of meeting the finances that we need to tackle the epidemic. We agreed that there is a core need for not only increased, but also more sustainable and more predictable, financing, so that we can achieve the universal access goals that all of us, both North and South, have signed up to and committed ourselves to achieving.

We realize that, in order to close the gap, new financing mechanisms need to be thought up, new commitments made and existing commitments fulfilled.

So how do we do that? We discussed two broad themes for achieving that goal. First, we looked at the possible mechanisms that all nations can work towards. We realize that increased sustainable and predictable financing cannot come from just one source, and that all possible sources need to be tapped and explored.

In the West, for example, a lot of the funds for healthcare come from taxes, insurance and other such schemes. But they are not the norm in many parts of the South. The panel recommended that we should work to ensure that schemes such as insurance and taxes be further explored, mobilizing national

resources, as well as to ensure that insurance schemes work, even in resource-poor settings.

We also discussed the issue of mobilizing our own domestic resources. We agreed that a long-term effort to end AIDS must depend on an increase in public expenditure, especially by low- and middle-income countries. That should include efforts to close gaps in domestic spending and national budgets. The example was given of Africa, which has committed itself to reaching an annual 15 per cent allocation for health in national budgets, to be shared across the region. In particular, countries that have not met that commitment should be encouraged to do so over the next couple of years.

Other suggestions included the example, provided by Zimbabwe, of the AIDS levy, which was described as an original response for mobilizing new resources locally by taxing 3 per cent of the income of employees to tackle AIDS in their country. That we well commended.

Another suggestion that was made for strengthening financing related to debt relief. The panel agreed that we can build on new responses for sustaining our fight against HIV/AIDS by utilizing savings from debt relief to boost HIV/AIDS spending without the conditionalities that are often tied to such relief. The example was cited of Nigeria, which recently won debt relief from the Paris Club, and as a result this year ploughed $42 million of its national resources into tackling AIDS.

There were also suggestions about donor countries increasing their support and scaling up, for example, their funding for the Global Fund. We noted that in recent months we have seen new, longer-term commitments. Instead of five-year commitments, we are seeing 10-year and 15-year commitments, including, for example, by the United States Government and the United Kingdom Government on education. Such substantial long-term commitments need to be replicated in other areas and by other Governments.

The panel discussed the issue of the Global Fund and agreed that it needs to be fully funded with long-term and sustainable commitments in order to meet the funding requirements and proposals of countries. It also agreed that other sustainable mechanisms should include funding the enrolment in insurance schemes of poor people living with HIV.

The panel also discussed other financing mechanisms, such as the International Drug Purchase Facility and the proposals by the United Kingdom relating to an International Finance Facility and to airline levy that could produce national resources in those areas.

We also heard the comments of panellists and other contributors from the private sector, who made quite interesting suggestions for scaling up financing for HIV/AIDS. They included ideas relating to the private sector’s offering pro bono services, in-kind donations and co-investment in prevention and treatment services for staff and their families. They also cited examples such as the Project Red campaign, which is generating millions in new funds and additional revenue for the Global Fund. Businesses can multiply their responses by providing financial, organizational and technical resources, as well as by leveraging the responses of others.

In the context of such new mechanisms, we also discussed a recommendation to bring down the cost of interventions, in particular the cost of second-line and third-line treatments, which could be reduced through further negotiations with the pharmaceutical industries and other initiatives that could led to the reduction in the cost of first-line treatment for HIV.

The second issue we discussed related to the principles that countries and partners should adopt in scaling up their responses. Once principle that was recommended was that all of us focus on prevention, care, support and treatment as joint initiatives. Even though the panel acknowledged that an increasing number of people were on treatment, we also talked about the need to ensure that we continue to prevent new infections, that the funds should be invested to that end and that Governments should commit new funds, in particular for prevention and treatment.

Secondly, in terms of principles, the panel discussed the importance of setting targets, milestones and goals, because they provide important benchmarks for measuring the scaling up of responses. The panel agreed that new funding resources are more accountable when they are benchmarked against achievable targets and milestones, especially when those targets and milestones take into consideration national plans and priorities.

The conditionalities attached to external funds were also discussed. It was pointed out that these

conditionalities are sometimes not related to the purpose of the funding and that they hinder the sustainability and predictability of the funds. Conditionalities should be limited and in line with country strategic plans, and then only to safeguard accountability and transparency.

The focus on performance was fully discussed. We agreed that one of the principles of financing was to increase the focus on performance and to ensure that programmes deliver the required results and that funds are directed to where they can be most effective.

Recipient countries were asked to have long-term national HIV plans for each sector and that such plans should be costed. That includes blueprints for the strengthening of sectoral systems — including human resources and links with the private sector — which make it easier for donors to support long-term plans.

Country ownership was stressed by a number of participants in the panel. Country ownership of plans and programmes must be at the centre of nationally driven initiatives to achieve universal access. Although such targets and agendas can be coordinated regionally and internationally, action should be national and local.

As HIV/AIDS is not just a health problem, it is very important that funding also address other sectors, including water, sanitation, nutrition, the social sector and education. Of course, those sectors also have a broad impact on the epidemic.

Overall, the national and international response to HIV must stay on course, and countries must accelerate their efforts to build their own capacities to respond to AIDS and to make better use of whatever funds that may be available. Multilateral organizations were also asked to scale up their responses and to ensure that grants, rather than loans, are provided. In national responses, we should ensure that there is access for commerce or business organizations and individual organizations, because they are the ones that are at the forefront of the epidemic and have the experience to make money work and to use it effectively.

Finally, the panel also discussed ensuring that it is not just recipient countries that are required to meet targets for mobilizing economic resources, such as is the case with African groups, which have a 50 per cent target; donor countries should also meet their own targets. The target set for member countries of the Organization for Economic Cooperation and Development is to contribute 0.7 per cent of their GDP to meet funding needs for HIV/AIDS. In ensuring that, we should see to it that no national plan goes unfunded.

I would like to conclude by quoting a statement made by one of the persons who participated in the discussion, a representative of the Treatment Action Campaign of South Africa: “In terms of financing for HIV/AIDS, the question should not be if, but when; the question should not be whether or not, but how.”

The Acting President (*spoke in French*): I now give the floor to the Rapporteur of panel 5, “Overcoming stigma and discrimination and changing the way societies respond to people living with HIV/AIDS”, Ms. Raminta Stuikyte, Director of the Central and Eastern European Harm Reduction Network of Lithuania.

Ms. Stuikyte (Lithuania), Rapporteur of panel 5: In 2001, Governments made commitments to promote and protect human rights in eight fields. Despite some progress in the global response to AIDS, we have failed to meet human rights goals, and the cost can be measured in human lives. Stigma, discrimination, inequality, violence and other human rights violations are major barriers to reaching universal access goals and to putting an end to the spread of HIV.

People living with HIV, women and vulnerable and marginalized populations face discrimination in all aspects of life. Whether in families, communities, health facilities, workplaces, schools or other settings, discrimination and negative attitudes disempower people. They prevent us from obtaining HIV-related information and testing, from adopting safe behaviours, from gaining access to prevention, treatment and legal services and even from living with respect and dignity.

Our panel discussed obstacles to effectively addressing stigma and discrimination. We focused on six key challenges. The first is insufficient involvement by people living with HIV and by representatives of other marginalized groups in the design, implementation and monitoring of responses. The second is inadequate political commitment and resources to address issues related to human rights, including stigma, discrimination, women’s rights and inequality. The third is inadequate enactment, review and enforcement of legislation to protect the rights of people living with HIV, women and vulnerable populations, to decriminalize populations and to ensure

access to HIV services. The fourth is insufficient commitment to addressing gender-based rights violations and to ensuring the access of women and girls to HIV and sexual and reproductive health services. The fifth is double discrimination on the basis of the perceived mode of HIV transmission: the distinction between so-called innocent victims of HIV and those who are "guilty" and "deserve" to be infected. And the last challenge that we identified and focused on is insufficient information and misconceptions about HIV/AIDS, people living with HIV and vulnerable populations.

Twenty-five years into the epidemic, we know what we need to do. We must empower people living with and affected by HIV, enshrine their rights in law, build political commitment, ensure adequate funding to eliminate stigma and discrimination, and monitor progress. Real empowerment and active and meaningful participation of people living with and affected by HIV is imperative. Involvement and participation means more than just inviting people living with HIV, drug users or young people to meetings. It means really involving them in making decisions that affect their lives. It means sharing power. It means building alliances to overcome inaction, incorrect action, denial, stigma and discrimination.

Universal access demands adoption and enforcement of anti-discrimination legislation and promotion of the right to comprehensive sex education and information, to women- and youth-friendly health and social services, to harm reduction, including clean needles, substitution treatment, and comprehensive workplace policies and programmes, and to the safeguarding of rights, confidentiality, privacy and informed consent.

We cannot achieve universal access by denying vulnerable groups or by neglecting to empower, involve and protect the rights of injection drug users, sex workers, men who have sex with men, prisoners and undocumented migrants. Governments must abolish the criminalization of people on the basis of their addiction, their sexuality or their poverty. People belonging to vulnerable groups must have equal and non-discriminatory access to services, and progress in delivering those services should be carefully monitored.

We must all be accountable to the human rights commitments already made. Real commitment and resources are needed from all sectors of society, including from political leaders at all levels; from civil society advocates; from religious authorities and leaders; from people living with HIV and members of affected communities; from parliamentarians; from employers, trade unions and the private sector; and from women's groups, youth leaders, donors and the United Nations system.

Commitments to protect human rights, combat stigma and discrimination should be monitored to measure the progress made and our successes and failures.

No progress can be made in our response to HIV/AIDS without the involvement of those people who are living with it. True progress is possible only in partnership with affected communities. People living with HIV are part of the solution, not the problem, as we have heard repeatedly today. This includes all affected people: women, injecting drug users, men who have sex with men and other affected communities among us. This means all of us.

Lastly, we spoke of the fact that our main focus should be on bridging the gap between our words and our actions. We must bridge the gap between our statements of goodwill made in panels and round tables and the actual commitments undertaken in the political declaration and our actions in that respect. It is time to deliver on our commitments.

The Acting President (*spoke in French*): This concludes the two days of comprehensive review of the progress achieved in realizing the targets set out in the Declaration of Commitment on HIV/AIDS.

The General Assembly has thus concluded this stage of its consideration of agenda item 45.

The meeting rose at 6.10 p.m.