

Global Consultation on the Sexual and Reproductive Health and Rights (SRHR) of People Living with HIV

Consultation Report

Amsterdam, the Netherlands
5-7 December 2007



Table of Contents

Executive Summary	3
Amsterdam Statement	5
1 Background	6
2 Addis Ababa to Amsterdam	7
3 Amsterdam Consultation	8
4 Process of Consultation	11
5 Discussions Leading to Recommendations	12
A. Health Systems	12
B. Prisoners	13
C. Crosscutting Gender Issues	13
D. Monitoring & Evaluation	13
E. Training	13
F. Legal	14
G. Stigma	14
H. Research	14
I. Young People	15
6 Moving Forward	16
Appendix A: Amsterdam Statement	17
Appendix B: List of Recommendations	18
Appendix C: List of Participants	21
Appendix D: Consultation Agenda	23
Colofon	25

Executive Summary

A global consultation on the Sexual and Reproductive Health and Rights (SRHR) of People Living with HIV was held in Amsterdam, The Netherlands, from December 5-7 2007. The consultation was co-convened by three key international networks: the Global Network of People Living with HIV (GNP+); the International Community of Women Living with HIV/AIDS (ICW); and Young Positives (YPoz); in partnership with UNAIDS, the United Nations Fund for Population Activities (UNFPA), the World Health Organisation (WHO), EngenderHealth and the International Planned Parenthood Federation (IPPF). This consultation was financially supported by the Ford Foundation, the William and Flora Hewlett Foundation, the David & Lucille Packard Foundation, UNFPA, The Netherlands Ministry of Foreign Affairs, WHO, UNAIDS and the Dutch AIDS Fonds. The aim of the consultation was to bring the GIPA Principle directly to bear on SRHR issues through a consultative process with HIV-positive people from around the world and deliver key recommendations for a Guidance Package to support SRHR issues in areas of Advocacy, Legal and Policy Issues, and Health Systems. The Guidance Package is intended to help anyone concerned with public health and human rights (whether as a health professional, policymaker or an advocate) to better understand why and how to meet the sexual and reproductive health needs and rights of people living with HIV.

The overall objectives of the consultation included the following:

1. Agreement on a vision statement which would form the first part of the comprehensive guidance package;
2. Identify an agenda for further debate, research and action;
3. Inform and contribute to the finalisation of the guidance document to fully capture diverse perspectives;
4. Stimulate stakeholders to take action on the recommendations generated at the consultation;
5. Strategise dissemination and implementation of the outcomes of the consultation; and
6. Agree on a one page position statement, which would be drafted before the consultation and be based on key issues arising from the vision statement. The vision will be collective and focus on certain common threads that will help shape public policy and will simultaneously ensure and reflect the diversity of perspectives.

An important aspect of the consultation was the development of a Statement on Sexual and Reproductive Health and Rights of PLHIV emphasising their right to fully enjoy sexual and reproductive health and rights including the enjoyment of sexual pleasure, and to enjoy the freedom of choice regarding reproduction, marriage and family planning.

The consultation brought together 65 participants representing every region of the world and representing communities of HIV-positive women, young people, men – both heterosexual and homosexual – transgender people, sex-workers and IDUs. The structure of the programme on the first day was to maximise on cross-cutting dialogue between participants through intense group work that covered three key areas relating to the discussion papers that will form part of the Guidance Package: **Advocacy** relating to the sexual and reproductive health and rights of people living with HIV; creating a supportive and enabling environment for **Legal and Policy** considerations; and creating and strengthening a supportive **Health System** to meet the sexual and reproductive health and rights and needs of people living with HIV.

Keynote speaker Dr Peter Piot, Executive Director, UNAIDS, who officially opened the consultation, spoke on a wide range of SRHR issues. Amongst these he noted that the “*sexual and reproductive health rights of PLHIV are not necessarily the most popular topics in society. There have been serious violations of SRHR of people living with HIV globally.*” Dr Piot continued on legal issues and noted that “*in the legal and policy environment SRHR issues can be both supportive and problematic*”. As an example of where laws can be problematic, Dr Piot cited the increasing number of countries introducing laws to criminalise HIV transmission.

As well as Dr Piot making his keynote address, this session was used to allow for a much longer question and answer session than usual. The following were some of the many questions asked:

On a question raised from a young PLHIV regarding a lack of support and resources for youth, Dr Piot responded that a new generation of young PLHIV is emerging and that we have to adapt to their ways of thinking and responding to AIDS. UNAIDS is fully aware of the obstacles and challenges young people face when trying to access SRH services, such as legal barriers of age in some countries. Dr Piot appealed for younger PLHIV to become ambassadors for change and to become more involved in SRHR issues specific to youth.

On the issue of funding, and red-tape involved when NGOs try to access funding through Government sectors Dr Piot responded that UNAIDS is fully aware of this challenge in some countries and that more resources are being channeled directly to NGOs who have proper financial mechanisms in place. Dr Piot will also raise this point with representatives of the Global Fund.

Dr Piot reminded participants that he welcomed PLHIV to email him with requests and concerns, especially when other avenues had been exhausted, or where people felt that they were being ignored or not responded to by the UN systems for which he had responsibility. However, he cautioned that to get a good response meant asking smart questions. This openness and invitation to dialogue was welcomed by participants.

Dr Piot concluded his presentation by highlighting the important role that GIPA still has to play. He noted, *“The process of this global consultation has attempted to ensure that not only are people living with HIV the centre of the response, but that their issues are addressed in a concrete manner. This is GIPA in action. GIPA needs to be reactivated and given new life to ensure that it is meaningful. This means all of us – governments, the UN, other partners, and you as people living with HIV – must challenge others and ourselves.”*

Amsterdam Statement on Sexual and Reproductive Health and Rights for People Living with HIV

We as 65 representatives of global networks of people living with HIV assert our sexual and reproductive health and rights free from discrimination, criminalisation, stigmatisation and judgment.

Who we are:

As people living with HIV from diverse ethnic and cultural backgrounds we acknowledge the disparities of access and diversities of experiences among people living with HIV around the world. Representatives at the meeting included women, transgender people, young people, heterosexual men, gay men, lesbians, bisexual people, current or former people who inject drugs, faith-based people, people with disabilities, current or former sex workers, former prisoners and people in detention settings, migrants, refugees, internally displaced people, men who have sex with men, and Indigenous people.

Our sexual and reproductive health and rights:

- People living with HIV have the freedom of choice regarding consensual and pleasurable sexual expression;
- People living with HIV have the freedom of choice regarding reproduction, marriage and family planning;

- People living with HIV have the fundamental right to access sexual health information and comprehensive sexual health services¹.

Exercising our sexual and reproductive health rights:

People living with HIV play a vital role in decision-making that affects our own sexual and reproductive

health and rights and we underline the importance of implementing Greater Involvement of People living with HIV/AIDS (GIPA), Meaningful Involvement of People living with HIV/AIDS (MIPA) and Full Involvement of People living with HIV/AIDS (FIPA) at all levels including the choice, design, implementation, monitoring, and evaluating of sexual and reproductive health services.

Amsterdam Statement on Sexual and Reproductive Health and Rights for People Living with HIV

- Through responsibly asserting, ensuring, and experiencing our sexual and reproductive health and rights we are contributing towards reducing the impact of the HIV epidemic, public health and shared responsibility.
- To fulfill collective responsibility we call on international, regional, and local organisations, governments, funders, and civil society including service providers, NGOs, FBOs, and other stakeholders to acknowledge our sexual and reproductive health and rights and meaningfully involve us in developing, implementing, and integrating policies and services to support us in creating an enabling environment to exercise our rights.

¹ Comprehensive sexual and reproductive health services include access to commodities including male and female condoms, water-based lubricants, gloves, antiretroviral therapy, sterile injection equipment, opioid substitution therapy, infertility treatment including assisted reproduction, semen washing, emergency contraception, sexual PEP, and support services after sexual assault regardless of gender, age, sexuality, cultural background, ethnicity, religion, income, educational level, environment, situation, and context.



1 ■ Background

Sexual and reproductive health is important to us all, at all stages of our lives. Yet, globally far too many PLHIV are denied their right to sexual and reproductive health. Millions of women and men lack access to contraception and to the sexual and reproductive health information and services they need in order to choose their family size and improve their own and their children's life chances. Millions more people are living with HIV and sexually transmitted infections that could have been prevented or treated.

A significant proportion of HIV-positive men and women report that they want to have a child or another child in the future. And when they are asked why, they talk about the pleasure and happiness that comes with being a parent – answers that, not surprisingly, are similar to those given by HIV-negative people. Moreover, pregnancy may be a time of high self-esteem for women, and parenting may help combat the negative effects of living with HIV for women and men. At the same time, those living with HIV who are considering parenthood raise concerns about the effect a pregnancy may have on a woman's health, the risk of transmitting the virus to their newborn, and whether they will be able to have a long, healthy life in which to love and support the child, and – should they die – who will take care of their children.

There is a compelling need for specific services that address the sexual and reproductive health of people living with HIV. Such services are not delivered in a vacuum. They are set against a backdrop of large-scale challenges that impede service delivery and people's ability to access health care. At the same time, meeting the sexual and reproductive health needs of people living with HIV could make an important contribution to resolving these overarching challenges. Finding ways to provide more integrated services for people living with HIV could play an important role in strengthening fragile health care systems and in bridging the divide between sexual and reproductive health and HIV policies and programmes. Other key actions, such as intensified training and ensuring an enabling environment in the workplace, would go a long way toward improving the quality of life of people living with HIV.

“Partners didn't understand how to engage people living with HIV at the Addis Ababa consultation on sexual and reproductive health: we were on the sidelines.”

Dr Kevin Moody, International Coordinator of the Global Network of People Living with HIV/AIDS (GNP+)



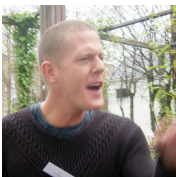
2 ■ Addis Ababa to Amsterdam

The urgent need to ensure sexual and reproductive health and rights of people living with HIV was the theme of a global consultation co-convened in Addis Ababa, Ethiopia, on March 27-30, 2006, by Engender-Health, UNFPA and WHO in collaboration with GNP+, YPoz, ICW, and IPPF. The objectives of the consultation were to initiate a dialogue on key issues, challenges, and opportunities in policies and programmes that will support the sexual and reproductive health of people living with HIV. A series of background documents was commissioned to gain information and evidence on the sexual and reproductive health needs and desires of people living with HIV. WHO commissioned six background papers based on the recommendations of an expert committee, including IPPF, ICW, GNP+, The Guttmacher Institute, UNAIDS, PATH and the Population Council. These papers reviewed the available evidence on policies and programmes that support the rights of people living with HIV to sexual and reproductive health and examined the challenges and obstacles at the legal, policy, and service delivery levels with regard to parenthood, sexual health, contraception, abortion, and fertility, the perspectives of health care workers, and the perspectives of people living with HIV regarding testing and counselling².

The co-conveners endorsed the proposed recommendations presented by the HIV-positive networks on the final day of the meeting, which included consulting with HIV-positive communities during the development of the proposed guidance documents. The process leading to the global consultation of people living with HIV was led by the Global Network of People Living with HIV/AIDS (GNP+), Young Positives and the International Community of Women Living with HIV/AIDS (ICW), in conjunction with key HIV-positive networks worldwide.

“We need more of this! Enough of the abuse of PLHIV! We need more action and less talk.”

² Reproductive Health Matters, 2007, Ensuring Sexual and Reproductive Health for People living with HIV



3 ■ Amsterdam Consultation

The guidance documents on Advocacy, Legal and Policy, and Health Systems considerations developed after the Addis Ababa meeting were used as a starting point for dialogue. To ensure that a common understanding of what is meant by human rights related to sexual and reproductive health working groups examined and debated their own definitions of what advocacy, legal and policy issues and health systems meant to them personally and to their respective constituencies.

It became evident from this early beginning that a vast and diverse meaning exists between people and their own definitions which created an excellent environment for debate. Each working group developed both specific and general recommendations that reflect the different topics covered and adopted within each group.

Subsequently, participants divided into one of four discussion groups focusing on thematic areas of advocacy relating to the sexual and reproductive health and rights of people living with HIV; creating a supportive and enabling environment for legal and policy considerations; and creating and strengthening supportive health systems policies. In addition to yielding important feedback, these discussions also led to the objective of the consultation; to provide critical recommendations that should be included in the development of the Guidance Package. Highlights of these discussions are:

Advocacy

People living with HIV have been talking about sex and reproduction from the beginning of the epidemic. HIV and AIDS forced gay men to redefine their sexuality and incorporate condom use in order to protect themselves

and their partners from HIV and other sexually transmitted infections (STIs). From North America to Australia, they successfully articulated “safer sex” messages into peer education campaigns. More recently, organisations of women living with HIV have broadened the discussion to include issues and choices related to reproduction, including contraception, fertility, pregnancy, termination, birthing, and breastfeeding.

Programmes and policies, however, have been slower to address sexual and reproductive health and rights. Early in the epidemic the focus was on preventing HIV, particularly among “vulnerable groups” of people, sometimes without acknowledging that people with increased vulnerability to HIV are part of the general population with the same needs and desires as anyone else.

However participants felt that without strengthening PLHIV networks and individuals it would not be possible to put in place and promote policies and programmes that support access to comprehensive sexual and reproductive health information for PLWHIV men, women, and transgender people.

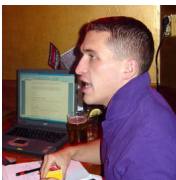
This work needed to happen in partnership with Governments, who needed to acknowledge that the most effective promoters and initiators of such programmes are PLHIV themselves. Furthermore it was felt that these responses needed to ensure that PLHIV networks and individual PLHIV were included as partners on local, state, national, and international decision making bodies that directly affect PLHIV reproductive and sexual health policies and programmes.

It was also felt that PLHIV involvement in SRH services needed to be meaningful. At minimum it should include PLHIV gender parity and a real voice in the design, implementation, staff monitoring and evaluation of SRHR related policy programmes and resource allocation. A principle that was discussed was that of advocating for only those organisations that demonstrate that 25% of their decision-making bodies included trained and capable PLHIV receiving HIV funds for SRHR services for PLHIV; and that being criteria for bilateral, multilateral, private, public and foundation funding.

Legal and Policy

In most ways, the sexual and reproductive health-related rights, needs and aspirations of people living with HIV are no different from those of people who are HIV-negative. For example, everyone has the right to decide whether and when to have children. All pregnant women need prenatal care and a skilled attendant to assist with childbirth. Young people aspire to understand the physical changes of their bodies and how to responsibly enjoy their emerging sexuality. In many places, however, existing laws and policies fail to support the ability of people living with HIV to exercise these rights and achieve their aspirations. Even worse, certain laws and policies severely constrict the sexual and reproductive rights of HIV-positive people.

National governments can improve the situation, first, by enacting, implementing and enforcing laws that prohibit discrimination against people living with HIV. These laws can make it less difficult for people living with HIV to obtain sexual and reproductive health care,



as well as employment, education, health insurance, housing and other social benefits. Governments can also develop and implement national frameworks and guidelines that explicitly protect the sexual and reproductive health of people living with HIV.

Sexual and Reproductive Health-Related Laws and Policies: Everyone has the right to health, and the primary aim of providing sexual and reproductive health services to people living with HIV should be to safeguard this right. Supporting the sexual and reproductive health needs of people living with HIV also has clear public health benefits, as it enables people with HIV to live healthier, more productive lives and to better protect others from infection.

Criminalization of HIV transmission: Some governments have made the transmission of HIV from one person to another person a criminal offence. Enacting these laws may give the general public the impression that policymakers are taking strong measures against HIV. This is particularly true in countries where many women are being infected by husbands or regular sexual partners. However, the reality of criminalization of HIV transmission is that it can create additional public health problems, rather than protecting people from HIV.

Family planning and abortion: To plan their families, women living with HIV have the same need for contraception that all women do. All family planning methods, including hormonal contraceptives and emergency contraception, are good options for HIV-positive women. Any contraceptive method can fail, and some women with unwanted pregnancies decide not to carry their pregnancies to term. An HIV diagnosis can prompt a pregnant woman to seek an abortion. Worldwide, nearly 70,000 women die following unsafe abortions every year, nearly all in countries where abortion is illegal, as it is for most women in much of the world.

Marriage, divorce, and child custody: People living with HIV should not face any restrictions on their right to marry or have children. Entering into marriage, and childbearing, are human rights, described in international agreements including the Universal Declaration of Human Rights and the International Guidelines on HIV/AIDS and Human Rights.

Male Circumcision: All men opting for male circumcision have the right to receive full information on its benefits and risks, and once fully informed, men living with HIV should be permitted to undergo the procedure (unless it is medically contraindicated). Where male circumcision is provided for minors (young boys and adolescents), the child should be involved in the decision-making and given the opportunity to provide consent, to the extent he is capable depending on his age. There is a concern that circumcision status could become another way in which HIV-positive men can be further separated from mainstream society and be at risk for stigma and discrimination.

Transgenderers: The legal status of transgenderers varies from country to country. Few countries have laws protecting transgenderers from discrimination. Transgenderers may be treated as mentally ill, or their existence may be completely unrecognised. Legal invisibility flows through to governments largely ignoring the sexual and health needs of this group. Another for concern is the designation of sex on legal documents, such as driving licenses, passports and birth certificates, as well as on medical records.

Health Systems

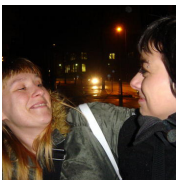
People living with HIV wish to have sex, to bear children, to prevent unplanned pregnancies and to protect their sexual health. Yet the stigma and discrimination that people PLHIV confront in all aspects of their lives is compounded by the fact that sexual and reproductive health policies, programmes and services often fail to take into account the unique needs of those who are HIV-positive.

This is in part because health systems in some countries simply lack the human and financial capacity to meet their people's health needs. Specific gaps and weaknesses in policies, training and programmes further undermine the ability of health systems to support the sexual and reproductive health of PLHIV.

Accessible, comprehensive sexual and reproductive health services are the cornerstone of efforts to enable people to make informed, safe, and healthy choices, particularly so for PLHIV and they need to be addressed within local, national, and international development plans.

Health care personnel: A severe shortage of skilled health care workers seriously hampers the expansion of comprehensive services for people living with HIV. WHO estimates a current worldwide shortfall of some 4.3 million health workers, including 2.4 million doctors, nurses and midwives, due to a combination of factors including low or unpaid salaries and poor training, lack of supervision and poor working conditions.

Current harm reduction programmes do not address the needs of transgender PLHIV. Harm reduction programmes need to provide targeted services to transgender PLHIV which is free of stigma and discrimination.



HIV testing: Knowing their HIV status helps people protect themselves and others from STI infections and re-infection, conceive and give birth safely and obtain appropriate treatment, care and support. People living with HIV should be involved in the development of testing programmes in communities.

Sex education: Many people diagnosed with HIV report that they did not fully understand that their sexual behaviour put them at risk of infection. Research shows that good quality education on sexual health and HIV reduces unwanted pregnancy, STIs and HIV, and mitigates stigma and discrimination against people with HIV.

Psychosocial support: People living with HIV need psychological and social support to help make informed decisions about health, cope with illness and tackle stigma and discrimination. From a sexual and reproductive health perspective, specifically, such support might address the need to deal with pressure from families and communities to have or not to have children, violence and fear of violence, other rights violations such as widow inheritance, how to negotiate safe sex, judgmental attitudes related to ongoing sexual activity and worries around disclosure of HIV status to partners.

As for so many other aspects of basic health, improving reproductive health care and rights for PLHIV depends on health systems strengthening. Increasing access to sexual and reproductive health services requires adequate resources (both financial and human), accountability between policy makers, providers and citizens, and strengthened public institutions. The critical shortage of service providers and other human resources for health calls for both short- and longer-term responses to problems such as low pay and poor incentives, migration, deployment and retention. Building effective demand for sexual and reproductive health services for PLHIV means commitment to giving PLHIV more say and improving their ability to hold providers accountable for the delivery and quality of services.

“This is my first time coming out disclosing my positive status to a group of people and feeling totally comfortable.”



4 ■ Process of Consultation

The objective of the consultation; to provide critical recommendations that should be included in the development of the Guidance Package was achieved in the remaining two days of the consultation. Participants divided into four thematic working groups that they self-identified with or had an interest in: women; men; IDUs; sex workers; transgender people, and other self-identified vulnerable groups; and youth.

The consultation resulted in 39 recommendations through a facilitated synthesis and refining of interactive group work discussions. Of the recommendations presented by participants during plenary sessions many were seen to be similar in content. A further process of synthesising the recommendations was undertaken by the key facilitators of the consultation which resulted in 16 key recommendations being presented to GNP+, ICW, YPOZ and Partners.

However, it was felt that not everyone had a mandate from their respective constituencies to adopt these recommendations and that further discussion must take place. All participants agreed that continued discussion must take place for key people/constituencies to have an opportunity to comment on, or have further input to, the recommendations. To assist this, GNP+, ICW and YPOZ implemented a discussion forum on a Yahoo web server where meeting participants had the opportunity to comment further on the recommendations clarifying and refining the work carried out at the meeting.

This site was moderated by Mr. Julian Hows one of the lead facilitators. The recommendations in this report are the result of that additional input.

Parallel to the Yahoo group an on-going process of discussion between the networks and supportive organisations around the recommendations will be continued via an online consultation process, followed by Living 2008: the Positive Leadership Summit for people living with HIV, on 31st July and 1st August 2008 in Mexico City. Sexual and Reproductive Health and Rights is one of 4 major themes that will be explored and it is anticipated a final presentation of recommendations will lead to an Advocacy Agenda for PLHIV for the next 18 to 24 months.

“The diversity of people attending and participating at this meeting was very encouraging. The level of participation also ensured as many voices as possible were heard.”



5 ■ Discussions Leading to Recommendations

A Health Systems

It was agreed by all participants that Health Systems need to be holistic, flexible, and creative to be able to include and respond to the rights and the different sexual and reproductive health needs of people living with HIV, especially HIV+ women who are sex workers, and IDUs, as well as prisoners.

Continuum of Care: Although HIV and AIDS touch all aspects of society, health systems are, and will remain, at the forefront of efforts to halt the disease. However, there is a lack of recognition and understanding of the links between the provision of HIV and AIDS services and the broader health systems required to ensure a sustainable, effective response to the epidemic in the long term. A comprehensive continuum of SRH services for PLHIV must be advocated for that begins from birth (particularly for people born with HIV) through childhood, adulthood and into old age.

Comprehensive Services: In any health system, good health services are those that deliver effective, safe, good quality prevention and treatment to those that need it, when needed, with minimum waste of resources. This is critical for marginalised or vulnerable groups such as HIV-positive people – men and women, young people, transgender people, sex workers, MSM, IDU etc. In addition, services should be expanded, e.g. cancer care, STI services, PMTCT, contraception, psychosocial support.

Women: Around the world women now make up more than half of all people living with HIV. While the impact

of this epidemic on women has been devastating, many women with HIV are living longer and stronger lives thanks to new treatments. However, women infected with HIV may have less access to, or lower use of, health care resources. This may be due to: fewer financial resources; less access to transportation; and the added responsibility of caring for others, especially children.

Many experts also believe poverty, unemployment, and lack of education are helping to “drive” HIV infection among women. Women living with HIV must be able to access comprehensive services beyond just prevention of vertical transmission, including treatment and supporting programmes that specifically focus on women’s health issues.

Violence against women plays a huge role in increasing the risk of HIV infection for women. It is a key reason why women are more likely to become HIV infected than men, particularly during violent or forced-sex situations. Fear of continued violence is a factor in terms of seeking treatment. Women may delay being tested for HIV or fail to return for the results because they are afraid that sharing their HIV-positive status may result in continued physical violence. Women must have access to comprehensive post-sexual assault services, including STI management and emergency contraception.

SRH services must involve PLHIV gender parity in the design, implementation, staff monitoring and evaluation of SRHR related policy programmes and resource allocation. By adopting this principle only those

organisations that demonstrate that 25% of their decision-making bodies include trained and capacitated PLWHA will received HIV funds for SRHR services for PLHIV (this is a funding criteria for bilateral, multilateral, private, public and foundations)

Access to SRH commodities: Access to sexual and reproductive health services can play a crucially important role in helping to prevent HIV transmission by providing information, education to reduce risky sexual behavior, detecting and managing STIs and promoting the correct and consistent use of condoms. Access to modern contraceptives for married and unmarried HIV positive women is an important strategy that needs to be greater promoted. Lubricants must also be included in the list of essential SRH commodities and made widely available for HIV-positive women and men.

Linking HIV prevention and the prevention and treatment of STIs with family planning and maternal health interventions can improve outreach, reduce stigma, and save money by using existing resources and infrastructure. Microbicides are simultaneously one of the most promising areas of biomedical research into HIV and STIs and yet one of the most chronically under-funded when compared with resources made available for vaccine development.

Guidelines for health care workers for male involvement: Developing responses that address norms of masculinity and involve men across the range of prevention, testing, care, and support programmes is a key aspect of comprehensive HIV programmes. For instance, traditional norms of masculinity place men



and their partners at risk for HIV. Norms of masculinity also make men less likely to seek health care services or information. In addition, without men's support, women are often unable to negotiate condom use or refuse unsafe sex, access needed care and services, or share the burden of care. This is particularly relevant for women in sero-discordant relationships.

In promoting male involvement, programmes should:

- address masculine gender norms that promote risk-taking and place men, boys, and their partners at increased risk for HIV;
- promote developing and strengthening positive masculine gender norms that support health-promoting behaviours and gender equity;
- improve men's support for women's reproductive health, discussions about sexuality and safer sex practices, and women's decision making and rights;
- ensure that male involvement programmes carefully evaluate gender relations and the impact of such involvement so these strategies do not cause unintended harm (e.g., reinforce men's control over decision-making).

Harm reduction services – Transgender People:

Transgender PLHIV often experience prejudice and exclusion when trying to access specific Harm reduction services due to their identity. In particular, and for effective implementation of Harm reduction services specific to transgender people would require supportive legislation, and regulations and policies that take into account hormone injections, Sexual Reassignment Surgery and castration.

HIV-Positive pregnant IDUs: HIV-positive pregnant IDUs should continue to receive opioid substitution therapy through pregnancy and post-natal period. Remaining in treatment for an adequate period is critical for treatment effectiveness.

B Prisoners

Prisoners with HIV do not have the same life expectancy rates as a person with HIV living on the outside. Overcrowding, poor diet, poor medical treatment, stress, TB, difficulty in accessing family and community support, excessive and vindictive sentencing, lack of support programmes, racism, prejudice, sexism, violence - all of these societal problems are magnified within the prison setting, and then magnified many times over in their impact on prisoners living with HIV. All of these factors work towards shortening a prisoner's lifespan.

Prisoners living with HIV have a right to maintain their health. The law is that whatever medical treatments and health care is available to persons in the community, should also be available to persons in prison. It is clear that prison systems must implement policies to facilitate this right. Prisoners living with HIV must:

- be guaranteed access to the medical practitioners and treatments of their choice;
- be allowed access to all available treatments including alternative therapies;
- have their special dietary needs met, whether required due to illness or as part of a therapeutic programme;
- have access to condoms;
- have access to opioid substitution therapy;
- have access to clean needles.

C Crosscutting Gender Issues

Gender based violence (GBV) is increasingly recognised as a public health problem and a violation of human rights. Furthermore, reproductive health workers are often the only care providers many women see. These professionals are on the front line in treating women who survive physical, sexual, and mental abuse. Yet, most reproductive health programmes are not equipped to handle such cases.

The links between HIV and gender-based violence are becoming increasingly apparent based on the findings of various studies conducted primarily in the United States and Sub-Saharan Africa. Findings show an

increased risk of HIV among women victims of gender based violence and show that being HIV-positive is a risk factor for violence against women.

This relationship has grave consequences for global health and human development, especially with regard to adult women, adolescents, and girls, who are most affected by sexual violence and are consequently more susceptible to HIV. Men must become more involved in reducing and eliminating GBV against women, transgender people, and men, through community driven campaigns on the reduction of GBV.

Transgender PLHIV must be recognised in their own right and not be subsumed under the category of men who have sex with men. It is the duty of the global PLHIV movement to ensure this happens, and in addition, that global networks begin to meaningfully involve transgender people into their programmes.

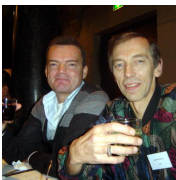
D Monitoring and Evaluation

Monitoring and Evaluation (M&E) is a critical component of any comprehensive HIV strategic planning. A comprehensive M&E framework should aim to monitor the resources invested, the activities implemented, services delivered as well as evaluate outcomes achieved and long-term impact made.

In parallel with administrative components to any M&E framework there should also be mechanisms that record any discriminatory practices towards PLHIV. With this in mind, the consultation agreed that in the context of PLHIV, a monitoring and evaluation reporting mechanism needs to be developed where PLHIV can document and report stigma and discrimination, and SRHR violations by health care providers (including SRH & HIV providers).

E Training

A specific curriculum should be developed in direct consultation with PLHIV for new and existing health care workers. A review of any curriculum should be undertaken by a credible PLHIV network. The curriculum



must be specific to PLHIV and SRHR needs and issues, including transgender people, youth and adults and should include sexual dysfunction relating to those on and off ARV therapy and other HIV-related treatments.

The need for trained and capacitated HIV-positive transgender, sex workers, young people and any other self-identified vulnerable group on SRHR advocacy is paramount.

The need for trained and capable PLHIV to provide direct SRHR services and advocacy is paramount.

F Legal

People with HIV have the same rights to liberty and autonomy, security of the person and to freedom of movement as the rest of the population. No restrictions should be placed on the free movement of HIV-positive people, and they should not be segregated, isolated, or quarantined in prisons, schools, hospitals or elsewhere merely because of their HIV-positive status.

People with HIV infection or AIDS are entitled to maintain personal autonomy (i.e. the right to make their own decisions) about any matter that affects marriage and child-bearing – although counseling about the consequences of their decisions should be provided.

There is a need for strong support from partner agencies (e.g. UN, Government, CSO) in developing a mechanism that will produce position statements, policy briefs, technical guidance documents, funding for advocacy in SRHR issues, and lobbying activities with national governments to repeal laws that criminalise HIV-positive people, and which prevent them from fully enjoying their SRHR.

G Stigma

Stigma/monitoring SRHR: From the moment the first persons were diagnosed with the syndrome that was called AIDS, social responses of fear, denial, stigma and discrimination have accompanied the epidemic.

Discrimination has spread rapidly, fuelling anxiety and prejudice against the groups most affected, as well as those living with HIV or AIDS.

It goes without saying that HIV and AIDS are as much about social phenomena as they are about biological and medical concerns. Across the world the global epidemic of HIV has shown itself capable of triggering responses of compassion, solidarity and support, bringing out the best in people, their families and communities. Yet the disease is also associated with stigma, repression and discrimination, as individuals affected (or believed to be affected) by HIV have been rejected by their families, their loved ones and their communities. This rejection holds as true in the rich countries of the north as it does in the poorer countries of the south.

Many reports reveal the extent to which people are stigmatised and discriminated against by health care systems. Many studies reveal the reality of withheld treatment, non-attendance of hospital staff towards patients, HIV testing without consent, lack of confidentiality and denial of hospital facilities and medicines. Also fuelling such responses are ignorance and lack of knowledge about HIV transmission.

A mechanism should be developed that will monitor the environment of SRHR issues of PLHIV in health care settings and programme and policies, and periodically monitor the situation through the PLHIV key networks (GNP+, ICW, YPoz and National PLHIV Networks).

A mechanism should be developed for the implementation and monitoring of guidelines and curricula that address stigma and discrimination for health care workers, school teachers, policy makers and programme staff on all SRHR issues that affect PLHIV, particularly for young people.

H Research

Involving people living with HIV in AIDS response activities can improve service delivery, empower them by ending their isolation, curb the effects of stigmatisation and discrimination, and add a powerful voice to prevention activities. The goal of research should be to identify and consolidate meaningful forms of PLHIV involvement and, more generally, to help participating networks, associations and PLHIV NGOs to identify the strengths and weaknesses of their activities and services in order to continually improve them.

Research issues should include:

- The need for an evidence-base to identify and provide services that meet the specific needs of all SRHR of various sub-groups of PLHIV;
- Research guidelines on SRHR need to be developed in consultation with HIV networks (WHO/UNAIDS.);
- The inclusion of the specific needs of young people and their informed participation and consent in New Prevention Technologies (NPT) research and the affects of ARVs on young people's physiological development including SRH. (NPT includes microbicides, HPV vaccines and AIDS vaccines);
- More research on HIV-positive transgender people on their SRHR needs and requirements;
- Review and document any legislation on criminalisation, sodomy and anti-decriminalisation of MSM and homosexuality that will identify gaps in epidemiological surveillance and develop appropriate and/or relevant research agendas that includes service provision.

Voluntary Male Circumcision: Male circumcision is one of the oldest and most common surgical procedures known. It is undertaken for cultural, religious, social as well as medical reasons. The evidence that adult male circumcision is efficacious in reducing sexual transmission of HIV from women to men is promising. The partial protective effect of male circumcision is remarkably consistent across the observational studies (ecological, cross-sectional and cohort) and three



randomised, controlled trials conducted in diverse settings have shown that, under these conditions, there is an approximate 60% reduction in risk of heterosexually acquired HIV infection from women to men.

However, this protective effect of male circumcision has not been proved among HIV-positive men. To date, there is no evidence suggesting that there is any protective effect of voluntary male circumcision on HIV-positive men or their partners. Some studies have suggested that there might even be an increased risk to the recently circumcised male's HIV-negative female partner, although increased rates of infections have yet to be proved. Currently, there is no recommendation from WHO and UNAIDS for HIV-positive men to be circumcised. There is also no evidence of any protective effect among men who have sex with men. Based on the current evidence it is difficult to recommend male circumcision when the HIV status is known to be positive.

That said, HIV-positive men who want to get circumcised and who are willing to follow the comprehensive prevention package pre- and post-surgery, should not be denied the procedure. It is unknown whether or not the state of "being circumcised" could become yet another reason to discriminate against HIV-positive men who choose to remain uncircumcised. This must be monitored carefully as volunteer male circumcision programmes are implemented.

I Young People

A group of young people living with HIV attended the global consultation meeting. They brought up the unique challenges that young people face in relation to their sexual and reproductive health rights. It also highlighted the distinctive needs of young people who were born with HIV and those who acquired it after sexual initiation.

Young people discussed in their group the many emotional, physical, and psychological issues related to their sexual and reproductive development and

produced to the consultation a list of their own recommendations that should be taken into account when developing the guidance package. These recommendations are:

■ **Youth Friendly Services:**

Experienced younger staff should be in clinics and organisations to provide information to new youth service users on SRHR issues. Information and services need to be relevant to young people. e.g., have young HIV+ audit services to ensure implementation and that youth are involved. There should be peer support for young PLHIV who will overlook monitoring and evaluation of peer support services.

■ **Medical Staff and Confidentiality:**

Develop an environment where medical staff have in place policies on confidentiality, and training issues of SRHR and YPLHIV.

■ **Psychosocial Support:**

Establish clinical services that assist YPLHIV in psychosocial support. Clinical staff must develop expertise that can identify YPLHIV with psychosocial support needs (depression, anxiety, suicide, progression with infection). There is a need to develop psychosocial programmes that deal with sexual health, and have tools of life skills within decision-making, (e.g., marital services, PMTCT).

■ **Health Rights:**

Educate YPLHIV on sexual and reproductive health rights, and on accessing services appropriate to YPLHIV and clinical care.

■ **Accessibility to Commodities and Services:**

Develop procurement systems that will monitor services of treatment and delivery of commodities for YPLHIV.

■ **Knowledge and Partnership:**

Develop a network where YPLHIV can share a platform to exchange experiences, strategies and information.

■ **Support for Born+ and pre-Adolescence+:**

Separated and integrated services within health service providers and within the community with specific support on health services that address the needs from those born with HIV, and those who were infected at a later stage.

■ **Prisoners Rights and Juvenile Detention Centres:**

Within the final paper, ensure that young prisoner's rights are acknowledged and that young prisoners do exist and have rights.

■ **Education on SRHR and Advocacy Training:**

Inclusion of young ethnic minorities in educating YPLHIV on SRHR issues; develop a Charter of Rights for YPLHIV and service providers on acknowledgment of SRHR responsibilities.

■ **Reproductive Health and Rights:**

Standardise policies on SRHR for young people; develop WHO guidelines on long-term treatment for born+ and pre-adolescent+.

■ **Inclusion of the needs for YPLHIV in NPT Research:**

Advocate too include YPLHIV in NPT research.

■ **Protective Environment and Policy for YPLHIV in Education Centres:**

Advocate for protective environments and policies for YPLHIV in pre-school, schools, colleges etc.



6 ■ Moving Forward

Participants were satisfied with the structure of the consultation including content and objectives. All agreed that building on from the Addis Ababa consultation had been achieved by addressing specifically the inclusion of PLHIV voices to ensure meaningful input, and recommendations in the development of the Guidance Package. The three networks will gain additional input through the Yahoo discussion forum and thereafter continue collaboration between the three networks and partners to finalise the recommendations in the form of an Advocacy Agenda during the Living 2008 Summit, July 2008 in Mexico City.

At the closure of the consultation, a key issue around SRHR was raised. In an effort to build capacity within the health care system an understanding that in designing policies and programmes to address the sexual and reproductive health needs of men and women living with HIV, policymakers, public health experts and national level programme planners must not only consider the best available scientific data but, to be truly successful, they must also take advantage of the perspectives, expertise and accumulated experiences of people living with HIV.

In addition, networks and associations of HIV-positive people and community-based organisations run by, and for, people with HIV have a key role to play at all stages in the process — from programme and policy design to the delivery and evaluation of sexual and reproductive health services. This includes involving HIV-positive men, women and youth in decisions about how and which services should be made available – for example, whether services are offered through a referral system or by adapting existing health services, such as family planning programmes, programmes for the prevention of mother-to-child transmission of HIV, or drug rehabilitation programmes. Moreover, governments and donors must invest in the capacity of organisations run by, and for, people with HIV so that they participate fully in policy and programme design of sexual and reproductive health services.

Everyone has the right to the enjoyment of the highest attainable standard of physical and mental health. States should take all appropriate measures to ensure, on a basis of equality of men and women, universal access to health care services, including those related to reproductive health care, which includes family planning and sexual health. Reproductive health care programmes should provide the widest range of services without any form of coercion. All couples and individuals have the basic right to decide freely and responsibly the number and spacing of their children and to have the information, education and means to do so.

Principle 8

International Conference on Population Development

A ■ Appendix - Amsterdam Statement on Sexual and Reproductive Health and Rights for People Living with HIV

We as 65 representatives of global networks of people living with HIV assert our sexual and reproductive health and rights free from discrimination, criminalisation, stigmatisation and judgment.

Who we are:

As people living with HIV from diverse ethnic and cultural backgrounds we acknowledge the disparities of access and diversities of experiences among people living with HIV around the world. Representatives at the meeting included women, transgender people, young people, heterosexual men, gay men, lesbians, bisexual people, current or former people who inject drugs, faith-based people, people with disabilities, current or former sex workers, former prisoners and people in detention settings, migrants, refugees, internally displaced people, men who have sex with men, and Indigenous people.

Our sexual and reproductive health and rights:

- People living with HIV have the freedom of choice regarding consensual and pleasurable sexual expression;
- People living with HIV have the freedom of choice regarding reproduction, marriage and family planning;

- People living with HIV have the fundamental right to access sexual health information and comprehensive sexual health services¹.

Exercising our sexual and reproductive health rights:

People living with HIV play a vital role in decision-making that affects our own sexual and reproductive

health and rights and we underline the importance of implementing Greater Involvement of People living with HIV/AIDS (GIPA), Meaningful Involvement of People living with HIV/AIDS (MIPA) and Full Involvement of People living with HIV/AIDS (FIPA) at all levels including the choice, design, implementation, monitoring, and evaluating of sexual and reproductive health services.

Amsterdam Statement on Sexual and Reproductive Health and Rights for People Living with HIV

- Through responsibly asserting, ensuring, and experiencing our sexual and reproductive health and rights we are contributing towards reducing the impact of the HIV epidemic, public health and shared responsibility.
- To fulfill collective responsibility we call on international, regional, and local organisations, governments, funders, and civil society including service providers, NGOs, FBOs, and other stakeholders to acknowledge our sexual and reproductive health and rights and meaningfully involve us in developing, implementing, and integrating policies and services to support us in creating an enabling environment to exercise our rights.

¹ Comprehensive sexual and reproductive health services include access to commodities including male and female condoms, water-based lubricants, gloves, antiretroviral therapy, sterile injection equipment, opioid substitution therapy, infertility treatment including assisted reproduction, semen washing, emergency contraception, sexual PEP, and support services after sexual assault regardless of gender, age, sexuality, cultural background, ethnicity, religion, income, educational level, environment, situation, and context.

B ■ Appendix - List of Recommendations

Global Consultation on the Sexual and Reproductive Health and Rights (SRHR) of People Living With HIV and AIDS (PLHIV)

Recommendations are divided into

- 1 Involvement and Inclusion
 - A Implementation
 - B Access:
 - C Training:
 - D Legal Issues
 - E Monitoring and Evaluation
- 2 Stigma-related Issues
- 3 Research issues
- 4 Responsibilities and Choices
- 5 Other Issues

Preamble

Recognising the need for Health Systems (HS) to be holistic, flexible, creative and comprehensive to be able to include, reach and respond to the different sexual and reproductive health needs and rights of people living with HIV, attention needs to be focused on:

- Providing a comprehensive continuum of SRH services for people living with HIV from birth (particularly for people born with HIV) to childhood, to adulthood to old age.
- Providing comprehensive care services and commodities for HIV-positive young and old, transgender, men and women (e.g. cancer care, sexually transmitted infections (STIs) services, prevention of parent-to-child transmission (PPTCT), contraception and psychosocial support).
- Providing comprehensive services for women living with HIV, beyond the prevention of vertical HIV transmission, including treatment and support programmes, focusing on women's health.
- Providing access to comprehensive post-sexual assault services, including STI management, emergency contraception and psychological support.
- Providing access to SRH commodities (incl. lubricants, female and male condoms, and rectal

and vaginal microbicides, when and if these become available).

- Developing guidelines for health care workers to involve men in conception, prevention of parent-to-child transmission and family planning services.
- Providing services for young prisoners, particularly those in juvenile detention, and female, male and transgender (in particular indigenous) adult prisoners.
- Providing harm reduction services that include the specific needs of HIV-positive transgender people (e.g., hormone injections, sexual reassignment surgery and castration).
- Providing harm reduction services that include the specific needs of HIV-positive female injecting drug users including ensuring that HIV-positive pregnant opioid injecting drug users should continue to receive pre-, during- and post-natal substitution therapy.
- Involving people living with HIV in the education of health care providers.
- Involving people living with HIV, particularly HIV-positive women, in decision-making processes on SRH at all levels.
- Ensuring that people living with HIV are involved in

the formulation of policy (especially where policies do not exist) and their implementation, monitoring and evaluation. This includes key populations, i.e., men who have sex with men, injecting drug users, sex workers, transgender people, indigenous people, people in detention settings, people with disabilities, and young people.

1 Involvement and Inclusion

1. In accordance with the Greater Involvement of People Living with HIV (GIPA) Principle, involve HIV-positive people, including key populations in the choice, design, implementation, monitoring and evaluation of SRH-related policy, programmes and resource allocation:
 - Only those organisations that demonstrate that their decision-making bodies are composed of 25% trained and capable people living with HIV can receive HIV funds for SRHR services for people living with HIV (these funding criteria are for bilateral, multilateral, private, public, foundation, etc)
2. Transgender people to be recognised in their own right and not subsumed under men who have sex with men (MSM), lesbian, gay, bisexual and transgender (LGBT) etc.
3. Global people living with HIV networks to meaningfully include transgender people in consultation processes.
4. Men need to be more involved in reducing and eliminating gender-based violence (GBV) against women, transgender people and men through community driven campaigns on the reduction of GBV.

Implementation

5. SRH organisations to ensure the involvement of people living with HIV in policy and programming as well as ensuring appropriate funding support for their involvement.
6. Transgender people to be involved in the choice, design, implementation, monitoring and evaluation of SRH policy and programmes.

7. Men to be more involved in programmes and campaigns at all levels to reduce and eliminate gender-based violence (GBV) against women, transgender people and other men.

Access

8. A comprehensive continuum of care from birth, to childhood, to adulthood (particularly for people born with HIV).
9. Guidelines for health care workers to involve men in conception services, prevention of parent-to-child transmission and family planning.
10. SRH services and commodities (including male and female condoms and lubricants).
11. Comprehensive care services and commodities for HIV-positive transgender (e.g., cancer care, STI services, PPTCT, contraception, psychosocial support).
12. Women living with HIV to obtain comprehensive services beyond prevention of vertical transmission and include treatment, care and support programmes which focus on women's health.
13. Comprehensive, accessible women-friendly services. HIV-positive pregnant opioid injecting drug users should continue to receive pre-, during and post-natal substitution therapy.
14. Comprehensive post-sexual assault services, including STI management, emergency contraception and psychological care.
15. Services for young prisoners, particularly those in juvenile detention.
16. Harm reduction services to include the specific needs of HIV-positive transgender people (e.g., hormone injections, sexual reassignment surgery and castration).

Training

17. Curriculum for new and existing health care workers to meet the SRH needs of people living with HIV (including transgendered people, young people and adults), including sensitisation on, and support for, the SRH of people living with HIV.
18. Train HIV-positive young people on advocacy.

19. Include sexual dysfunction of people living with HIV, both those on and off treatment, in training curricula.

Legal Issues

- There is a need for strong support (position statements, policy briefs, technical guidance documents, funding for advocacy SRHR, lobbying with national governments) from partners (UN, governments and civil society) to repeal laws that criminalise HIV-positive people and prevent them from fully enjoying their SRHRs. Work in this area should include:
20. Strong support from partners (UN agencies, governments and civil society) to oppose and pressure for repeal of laws criminalising HIV-positive people's rights to fully enjoy their SRH.
 21. Equity in adoption laws and custody of children for HIV-positive parents.
 22. Removal of laws contravening the right to marry and barriers to founding a family.

Monitoring and Evaluation

23. Monitoring and evaluation need to be supported whereby people living with HIV can document and report instances of stigma and discrimination and SRHR violations by health care providers, including SRH and HIV providers.

2 Stigma-related Issues

Eliminating stigma

- People living with HIV should be leading initiatives that will result in eliminating stigma. These initiatives should include:
24. Mapping and monitoring of GIPA best practices.
 25. Developing a tool to monitor the situation of SRHR of people living with HIV, (health care settings, and policies and programmes) and periodically monitor the situation through the people living with HIV networks, including The Global Network of People Living with HIV/AIDS, the International Community of Women, Young Positives and national people living with HIV networks.

26. Developing, implementing and monitoring guidelines and curricula for health care workers, school teachers, policy makers and programme staff, addressing stigma and discrimination and the SRHR of all people living with HIV, particularly that of HIV-positive young people, including specific training for school teachers and curriculum developers so that the SRH issues and needs of HIV-positive young people are included.

3 Research Issues

There is a need for ethical and adequate research and guidelines to provide the evidence base that will result in the identification of the specific SRHR of various sub-groups of people living with HIV and the services that need to be provided to address these needs. The guidelines should be developed as part of the partnership between the people living with HIV networks and partners. Examples of areas that need to be covered include:

27. The needs of young people in new prevention technology research.
28. The needs of young people in relation to research on new prevention technologies and the effects of antiretroviral therapies on HIV-positive young peoples' physiological development, including SRH issues, paying special attention to the informed participation of young people.
29. Research on HIV-positive transgender people's SRH rights and needs.
30. Review and document criminalisation and sodomy laws.
31. Review and document anti-discrimination of men who have sex with men and homosexuality to identify gaps in epidemiological surveillance and appropriate and relevant services.
32. Research on advisability of male circumcision of PLHIV.

4 Responsibilities and Choices

33. Positive behaviour and protecting oneself.
34. Promote VCT and referral with care and support.
35. Secondary and positive prevention is important but needs to be redefined by HIV-positive people if it is to be effective.

5 Other Issues

36. Legal recognition of identity and expression of transgender people as a prerequisite for realising their SRH rights.
37. Develop a charter of rights by, and for, young people living with HIV on their SRH rights and responsibilities, including the responsibilities of their service providers.
38. Support and promote knowledge sharing and partnership, networking, safe spaces and learning among and by young people living with HIV.
39. Advocate for protective environments and policies within educational systems policies for young people living with HIV.

C List of Participants

Participant	Country of Residence (Affiliation)
Greet, Beverly Joy	Australia
Raper, Stephanie Joy	Australia
Somda, Dakuyo Martine	Burkino Faso
Correia Gomez, Marco Paulo	Canada
McClelland, Alex	Canada
Ong Yong Yong, Rachel	Singapore
Chakrapani, Venkatesan	India
Henminlun/Loon Gangte	India
Yuvaraj, Anandi	India
Manggala, Yudi	Indonesia
Ratri, Candrika Phalita	Indonesia
Moradi, Amirreza	Iran
Akinyi, Elisabeth Osewe	Kenya
Ateka, Pamela	Kenya
Atieno, Muchembere Elizabeth	Kenya
Wangui, Elizabeth Isabellah	Kenya
Klavins, Sandris	Latvia
Sembereka, Sylvester MacDonald	Malawi
Gatsi, Jennifer	Namibia
Pant, Sunil	Nepal
Baziruwisabiye, Chantal	Netherlands
Fransen, Raoul	Netherlands (Young Positives)
Janssen, Hannah	Netherlands
Kuzwayo, Fezekile	Netherlands
Moody, Kevin	Netherlands (GNP+)
Welter, Francoise	Netherlands (GNP+)
Moala, Edward	Samoa

Participant	Country of Residence (Affiliation)
Cano Meza, Arely del Carmen	Nicaragua
Quinto Jr., Dionisio Orena	Philippines
Iwulska, Marianna	Poland
Pavel, Bogdan Maria	Rumania
Raducanu, Oana Maria	Rumania
Stephen, Roderick John	South Africa (reporter)
Wessenaar, David Jason	South Africa
Pengel, Ethel	Suriname
Dilmitis, Sophie	Switzerland
Doupe, Andrew	Switzerland (consultant)
Thomson, Kate	Switzerland (UNAIDS)
Singh, Gurmit	Switzerland (IAS, facilitator)
Akhmedova, Parvina	Tajikistan
Gray, Greg	Thailand
Williams, Deborah Violet	Trinidad & Tobago
Garner, Adam	UK
Hows, Julian	UK (facilitator)
Tima, Belinda	UK
Trossero, Alejandra	UK (IPPF, facilitator)
Walsh, Henry James	UK
Walters, Clint Lee	UK
Mellors, Shaun	UK (facilitator)
Corado, Ruby	USA
Collins, Toni	USA
Dockrey, Deloris	USA
Hull, Beri Colyn	USA
Lawson, Philippa	USA

Participant	Country of Residence (Affiliation)
Murray, Todd Alan	USA
Steward, Rhonda Ann	USA
Huyen, Huynh Nhu Thanh	Vietnam
Nguyen, Hoai Linh	Vietnam
Mashamba, Evelyn Sharon	Zimbabwe
Mungazi, Godfrey	Zimbabwe

Guest Speaker	Affiliation
Dr Peter Piot	UNAIDS
Partner Organisation and Funder Representatives	
Bekkers, Paul	MoFA the Netherlands
Collins, Lynn	UNFPA
Cottingham, Jane	WHO
Gray, Nicole	William & Flora Hewlett Foundation
Hawkins, Kate	Consultant
Klinkert, Els	MoFA the Netherlands
Lusti-Narasimhan, Manjula	WHO
Perchal, Paul	EngenderHealth
Thomson, Kate	UNAIDS
Consultation Organiser Representatives	
Bell, Emma	ICW
De Goei, Tanne	GNP+
Hale, Fiona	ICW
Tonnon, Jasper	GNP+

D Consultation Agenda

Day 1 – Wednesday 5th December

09.00	Welcome Statements from ICW , YPoz and GNP+ and presentation of the partners
09.30	Housekeeping – any pressing logistic issues for participants
09.40	Introduction to Facilitation process and documentation team and agreement on the agenda
10.30	Welcome of Peter Piot , Executive Director, UNAIDS Paul Bekkers, AIDS Ambassador for the Netherlands
10.45	Introduction to three areas of consultation
11.10	(1) policy and rights
11.30	Coffee Break
12.00	(2) health systems
12.20	(3) advocacy
12.40	Any further Questions for Clarification Instructions for the break-out groups
13.00 – 14.00	Lunch
14.00	Three break out groups dealing with : (1) advocacy, (2) health systems, (3) policy and rights.
15.15-15.45	Coffee break
15.45 -16.45	Continuation of working groups
16.45- 17.00	Closure – and any evening events caucuses etc

Day 2 Thursday 6 December 2007

09.00	Review of Previous Day – Overview of 'How it felt' /personal learning / reflections
09.15	Plenary Review of day 1 and introduction to the morning breakout sessions
09.30	Working Groups per constituency 1) Women 2) IDU's, Sex Workers, Transgender 3) Men Suggested groups....
10.30	Continue in same groups to review issues, challenges and opportunities presented previous day from all three of the areas and identify main issues of concern. Prepare for talk show – take risks!!!
11.15	Coffee break
11.45	Plenary 'Talk Show' Panel Discussion from working groups of seven individuals identifying themselves as being from one of the following 'constituencies' : IDU, Heterosexual Men, MSM, Transgender, Women, Young People
12.30	Lunch
13.30	Plenary to present group work for afternoon.
13.45	Thematic working groups per paper will incorporate the key issues identified in the morning relevant to key paper and start drawing out key recommendations (3 to 5)
15.00	Coffee break
15.30	Thematic groups continue with second part – looking at who is the main audience/target for each recommendation.
16.30	Wrap up of the day
19:00	Group Dinner

Day 3 - Friday 7 December 2007

09.00	Review of Previous Day – Overview of ‘How it felt’ /personal learning / reflections
9.15	Plenary presentation of key recommendations prepared on Day 2 per paper: (1) policy and rights, (2) health systems, (3) advocacy
9.45	Presentation of draft declaration for review: our position on this issue to present to external audiences.
10.00	Three groups to develop action plans: short, medium and long term
11.15	Coffee break
11.45	Plenary to present and agree actions and refining recommendations
13.00	Lunch
14.00	Plenary Session Open to Partners - Presenting key recommendations - Call for action - Declaration from this consultation
15.00	Coffee Break
15.30	Wrap-up session to agree on next steps including key partners
16.00	Evaluation of the meeting
16.30	Closure and farewells

For further information about this consultation, please contact either:

Global Network of People Living with HIV (GNP+)

P.O. Box 11726 · 1001 GS Amsterdam · The Netherlands

T +31 20 423 4114 **F** +31 20 423 4224

www.gnpplus.net **E** infognp@gnpplus.net

International Community of Women Living with HIV/AIDS (ICW)

Unit 6, Building 1 · Canonbury Yard 190a · New North Road · London N1 7BJ
United Kingdom

T +44 20 7704 0606 **F** +44 20 7704 8070

www.icw.org **E** info@icw.org

Stichting Young and Positive

Visiting Address:

Keizersgracht 390-392 · 1016 GB Amsterdam · The Netherlands

Postal Address:

P.O. Box 10152 · 1001 ED Amsterdam · The Netherlands

T +31 20 528 78 28 **F** +31 20 627 52 21

www.youngpositive.org **E** RFransen@icssupport.org

Consultation Team:

Lead Facilitators

Julian V. Hows United Kingdom julianhows@btinternet.com

Alejandra Trossero United Kingdom atrossero@ippf.org

Facilitation Support

Shaun Mellors United Kingdom smellors@aidsalliance.org

Gurmit Singh Switzerland Gurmit.singh@iasociety.org

Report

Rick Stephen South Africa jazman1@tiscali.co.za

Several participants utilised their facilitation skills to direct group break-out sessions – and attended briefing and review meetings with the organisers as part of this process. Sincere thanks to all who participated.