



CONFERENCE REPORT

**Responsibilities of Governments & Civil Society in the Fight against
HIV and AIDS in Africa – The Way Forward to 2015**

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Concrete Action Needs to be Taken towards Achieving Universal Access

Dear readers,

The 18-month program of the trio EU Council Presidency in force since January 2007, puts poverty-related and sexually transmitted diseases on the political agenda of the German, the present Portuguese and the coming EU Council Presidencies of Slovenia. And indeed, HIV and AIDS as well as the dialogue with Africa have been focal points of the German EU Presidency as well as the G8 Presidency in 2007. This was not lastly due to the lobby and advocacy work of VENRO. The International Conference "Responsibilities of Governments & Civil Society in the Fight against HIV and AIDS in Africa – The Way Forward to 2015", which took place at the threshold of the G8-Summit in Heiligendamm as well as prior to the European Council Meeting in June 2007, used the historic momentum of Germany's twin-presidency in order to remind the EU and the G8 of their promises related to Universal Access to prevention, diagnosis, treatment and care. By picking up the issue of Universal Access, the conference openly discussed opportunities and challenges of a comprehensive response to the HIV/AIDS pandemic and sharing lessons learnt from the past among representatives of African and European civil societies. The conference finally adapted strategies towards Universal Access to a changing environment and presenting a vision till 2015 to the relevant political decision-makers.

Several commitments towards achieving Universal Access have been made so far. Among them the "3by5 Initiative" of the World Health Organisation (WHO) and the promise of the G8 at Gleneagles in 2005 to ensure access to anti-retroviral treatment for all affected people by 2010. Universal Access as an integrated approach to combat HIV/AIDS has been taken up for the first time by the UN General Assembly High Level Meeting on HIV/AIDS in 2006. There, heads of state committed themselves to attain "Universal Access to comprehensive prevention programmes, treatment, care and support by 2010".

At this point there are only three years left to reach these goals. And more than half of the time has passed to reach the Millennium Development Goals (MDGs).

The momentum has to be kept by the EU, the G8 and the civil society and efforts have to be concentrated to achieve the targets mentioned above. We must adhere to concrete goals in order to move forward.

Even though efforts by the EU to fight the pandemic exist and strategic approaches such as the European Programme for Action to Confront HIV/AIDS, Malaria and Tuberculosis through external Action (2007–2011) are there, EU policy

does not provide any long term measures to actively promote Universal Access to Prevention, Treatment, Care and Support. As it is stated in the final communiqué of this conference, "we acknowledge the progress that has been made over the past years in increased funding and political commitment by the EU and the G8 countries. We are however deeply concerned that the resources available and political commitment demonstrated do not match the scope of the pandemic and the human suffering that it causes."

In Heiligendamm the G8 prospected the provision of at least 60 billion US-Dollar for achieving Universal Access and the MDGs dedicated to combat HIV/AIDS, tuberculosis and malaria.

However, the financial gap is recognized by the international community, a concrete financial plan is needed pointing the way towards achieving Universal Access by 2010. It is not enough to just increase resources but the EU and the G8 countries have to agree on a strategy how to promote prevention and make it effective, how to strengthen health infrastructure in developing countries and provide sustainable access to antiretroviral drugs and how to foster civil society and give comprehensive support to orphans and vulnerable children. Without ascertaining concrete political measures and time frames we will not be able to monitor the announcements of the political leaders.

The international conference, as a part of the VENRO EU Presidency Project "Prospects for Africa-Europe's Policies" regards itself in continuity of the Helsinki recommendations of the Finnish platform in October 2006 and the VENRO Manifesto in December 2006. The recommendations formulated by the participants in the framework of different thematically specific working groups were handed over to the Portuguese NGO platform in order to ensure continuous lobby work towards the commitments on Universal Access and to ensure that HIV/AIDS remains high on the political agenda of the EU. The EU-Africa Summit in Lisbon will demonstrate whether commitments were not only empty promises, but were put into practice so that millions of lives can be saved and the spread of HIV/AIDS can be halted and reversed. In that context civil societies in the North as well as in the South will play a vital role in holding their governments accountable.

I wish all readers interesting reading.



BERND PASTORS, VENRO BOARD AND MANAGING DIRECTOR OF THE GERMAN MEDICAL AID ORGANISATION ACTION MEDEOR E.V.

Promoting Intercultural Dialogue and Health-Related Development Issues

CHRISTIAN GRAMSCH, DIRECTOR OF PROGRAMMES,
DEUTSCHE WELLE

I am honoured to have the opportunity to welcome you here in the central office of Deutsche Welle (DW) broadcaster in Bonn. At first I would like to emphasize how fitting it is, that this conference takes place at DW broadcast centre in Bonn. The fight against HIV/Aids is an important topic in many of programs, which we broadcast in French and English, but also in Kiswahili and Arabic among others. What we find is that people have an interest in educational programs, in programs that inform about health issues, including the prevention of HIV/AIDS and other infections. This is why all our offers to Africa include weekly health programmes. But there are not only the medical aspects but also political aspects which this conference is going to deal with. What is Germany doing, what is Europe doing and what is Africa doing in the fight against HIV/AIDS? And in which forms can we cooperate with local citizens groups or grassroots organisations in the countries highly affected by HIV/ AIDS?

This might be the point at which I should give you an insight into how we work at DW and briefly outline our principles, our visions and values. DW is Germany's media visiting card throughout the world - with our television department, our radio department, our online department and the DW academy. Since more than 50 years, DW has been an innovative media enterprise which offers globally accessible multimedia information using the latest digital technology for broadcasting and production, in particular drawing on the expertise of a multinational team with some 1500 employees from 60 countries. What you see here is Europe's most modern broadcasting centre, where we produce programmes in 30 languages from Arabic to Urdu, from Bengali to Farsi. Of course we broadcast in German and English and also in the languages of the new and future member states of the EU and in several African languages. We reach some 35 million listeners with our radio programmes in Sub-Saharan Africa alone. In the future, internet will gain a more and more important role as more people gain access to this medium. This is why we are further strengthening our internet services. DW-WORLD.DE in Bonn is already one of the most successful internet services in the world. We want to



Christian Gramsch

maintain and expand this leading role.

Please allow me to say a few words about our mission. Our mission is to communicate German and European points of view as well as other perspectives. We promote intercultural dialogue to further international understanding and tolerance. We communicate the values of liberal democracy and support human rights. And even though we are funded by the German parliament, we report absolutely independently and on a pluralistic basis. An important part of our mission is to provide comprehensive and sensitive information to countries that lack free media, particularly in regions of conflict and war zones and we pass on our know-how to partners throughout the world. This is done by my colleagues from DW-Academy who offer trainings to journalists from Asia, Latin America, Eastern European countries and Africa. This is in brief what DW does and what we stand for. Thank you very much for this opportunity to outline our mission. I hope you agree with me that there could not be a better place for this conference and I hope you will find the time to get into contact with my colleagues from our different language services. I wish you all the best for your two-day conference in Bonn.

Thank you very much for your attention.

Winning the Battle against HIV and AIDS

DR. ERICH STATHER, STATE SECRETARY IN THE
FEDERAL MINISTRY FOR ECONOMIC COOPERATION
AND DEVELOPMENT

HIV/AIDS a Global Crisis

Every 10 seconds, somebody in the world dies of Aids. World-wide, 40 million people are HIV-positive; almost seven million have developed AIDS and more than 25 million have already died from the consequences of the disease. Within 25 years, the HIV/AIDS pandemic has become one of the greatest disasters facing humankind, continuing to claim millions of human lives year after year. HIV/AIDS is not only a medical but a global political, economic and social problem. The proportions of the human tragedy which Aids is causing for families and for entire nations are unimaginable. So I am glad that this issue is claiming so much attention during our twin-presidencies of the EU and the G8. Thank you very much for inviting me.

Germany's Contribution to International Goals

The fight against HIV/AIDS is the latter-day battle of humanism as Henning Mankell phrased it, and the Federal Government of Germany and the BMZ (Federal Ministry for Economic Cooperation and Development) in particular are determined to win the battle. We want to achieve Universal Access to prevention, treatment and care by 2010. We want to halt and reverse the spread of HIV/Aids by 2015. The German government gives high priority to this goal as is evident from its support for the decisions on HIV/AIDS control adopted at Gleneagles, the 2005 Millennium+5 Summit and the UNGASS+5 conference in 2006. The global fight against HIV/AIDS, tuberculosis and malaria is also a central issue of the agenda of the German presidencies of the EU and G8 in 2007. In March, the German government published its "Action Plan to Implement the Strategy of the Federal Government to Fight HIV/AIDS", which was drawn up jointly by the Ministry of Health and the Ministry for Economic Cooperation and Development. In that action plan we are defining five core elements of global and national efforts:

- Prevention and education,
- Access to testing and therapy,
- Respect of human rights,
- International cooperation
- Increased research

The German government has already increased its related commitment considerably in the past few years from about 20 million Euro (1998) to 300 million Euros annually since 2003. And it is aware of its responsibility to contribute to the



Dr. Erich Stather

fight against HIV/AIDS, tuberculosis and malaria. Accordingly, it will increase its contribution to that endeavour from around 300 million Euros per year to 400 million Euros in 2007. German bilateral development aid efforts for HIV/AIDS control are underway in more than 40 countries, relying on internationally recognized innovative approaches. In 15 countries, we are providing comprehensive program support to the health sector.

EU Presidency and G8 Summit

The European Union Council Conclusions that have been adopted underline the importance of strengthening health systems in the countries concerned and focussing action on women. Empowering women means weakening the AIDS pandemic. At the G8 Summit in Heiligendamm, HIV/Aids will be part of the agenda within the framework of the focus to Africa.

We are hoping to adopt decisions on the following goals:

- achieving Universal Access to HIV/AIDS prevention, diagnosis, treatment and care worldwide by 2010
- halting and reversing the spread of HIV and Aids by 2015 as a part of the Millennium Declaration and
- creating the requisite capacity in the health sector

There is a thematic focus on prevention, women, and health system financing/social protection. Under Germany's G8 Presidency, a report will be drawn up for the first time on the efforts of G8 countries in support of the global fight

“Cooperation with civil society is very important if our efforts to combat HIV/AIDS are to be successful.”

against HIV/AIDS, tuberculosis and malaria. We also want to achieve an appropriate replenishment of the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM). In the past five years, the Fund's work has saved 1.5 million lives – 100,000 each month, 3,000 every day!

In the second half of this year, we will organize a conference for the Fund's replenishment and Kofi Annan will be participating.

Within the framework of the EU, in the negotiations leading up to the G8 summit and in our multilateral and bilateral cooperation, we consider the following points as particularly important:

If the goal to Universal Access is to be reached, social security systems and health systems in particular must be strengthened. We also need to take action against the lack of qualified personnel. It is the responsibility of the industrialised countries to refrain from “poaching” trained health personnel from developing countries to address their own shortage of human resources, thus further exacerbating the dramatic situation in developing countries' health sector. Brain drain must be prevented rather than encouraged. We are therefore advocating a code of conduct for justice.

Since the introduction of ARV combination therapies, drugs have reduced mortality rates in industrialised countries by about 70%. Out of the 40 million infected people 6.8 million people in transition and developing countries urgently need such drugs. But at present, less than one third of them – merely 1.6 million people – are receiving this vital treatment. People who need antiretroviral therapy must be provided with access to affordable drugs.

We are therefore supporting local production as well as local laboratory capacities and certification of institutions in the poorest countries.

Prevention continues to be a central challenge in the fight against HIV and AIDS. As many as three quarters of all people at risk do not have access to condoms and information about HIV/AIDS. In all our activities, we are working with strong efforts particularly for the protection of women and girls because infection rates among women have risen dramatically worldwide. In Southern Africa, women now

account for 60 to 70% of HIV-positive People. Women's dependence on men often means that they have no way of protecting themselves against HIV/AIDS. Giving women access to education and economic independence is thus a relevant part in the frame of a comprehensive HIV/AIDS eradication strategy. Cooperation with Civil Society Governments cannot tackle the HIV/AIDS epidemic by themselves. Cooperation with the civil society players is very important if our efforts are to be successful. Local, national and international NGOs are important and indeed indispensable partners in the fight against the epidemic. NGOs are close to their target groups. They provide education, advice, care and advocacy. They enjoy the confidence of those affected.



Global Fund John Rae

And such confidence is crucial, because in the context of Aids it is vital to talk about taboo issues. I would therefore like to express my great appreciation of the work done by NGOs. NGO's expertise and experience are indispensable to reaching MDG 6. We need your committed work and your critical views regarding our work! I am thus particularly pleased that we are meeting for a dialogue among partners here in Bonn. Only if we combine our respective strengths, we can take systematic action against the epidemic. I wish you all a successful conference and I am looking forward with interest to your recommendations. Thank you very much for your attention.

Report of the Panel Discussion

Achieving Universal Access to comprehensive prevention, diagnosis, treatment, care and support is an important milestone on the way to combat HIV/AIDS and therefore reaching the MDGs. At the United Nations General Assembly High-Level Meeting on HIV/AIDS in 2006, international governments committed themselves to attain „Universal access to comprehensive prevention programmes, treatment care and support by 2010.“ In order to reach these targets, promises are not enough. Achieving Universal Access by 2010 requires concrete strategic and financial plans as well as additional financial resources, as Rolf Goldstein said in his opening statement. But how can Universal Access be defined? What are the perceptions from different perspectives? Which concrete steps towards this goal have been taken so far? What should be done in the future in order to attain Universal Access? And what are the barriers on the way? These issues were discussed between German and African representatives of the governmental and civil society sector in the framework of this panel discussion which was held at the beginning of the conference “Responsibilities of Governments and Civil Society in the Fight Against HIV and AIDS – The Way Forward to 2015“. The panel discussion was moderated by Sara Simon (CARE International) who allowed a lively and interesting exchange of perspectives. Gisela Lange (German Federal Ministry of Health) emphasized the priority of HIV/AIDS during the German EU-Presidency and referred to the EU Ministerial Conference in Bremen, where EU Member States explained their readiness to take up political leadership in response to HIV/AIDS in a transparent and accountable manner. Within the Bremen Declarati-

on, EU Member States made important political commitments, comprising the guarantee of human rights, protection of vulnerable groups including drug users and sex workers, comprehensive sex education and counselling including condom use, promotion of HIV prevention, treatment and care through community action programs, promotion of research including microbicides and vaccines and access to affordable medication. Lange welcomed the dialogue between governments and civil society from Europe and Africa and stressed on the vital role they play in the fight against HIV/AIDS. “We cannot do it without civil society.”

Marwin Meier (World Vision Germany) stated that despite several key documents which have been published by the EU on HIV/AIDS with involvement of civil society during the past 5 years, HIV/AIDS is losing its prominence within the EU. “More efforts are needed on the part of the EU,” according to Meier. He was also convinced that mainstreaming HIV/AIDS as a universal recipe as it is used by the EC is a dangerous trend.

Especially on the funding side mainstreaming would lead to less financial assistance for the fight against HIV/AIDS. Rolf Goldstein (Action against AIDS Germany) maintained that, more resources are needed to achieve Universal Access. In this context he also pointed at the importance of strengthening local health care systems. Universal Access does not only include availability of drugs at the respective health-care centres, it is equally important that there are functioning basic health care facilities that people in need are able to reach. “We appreciate that the German government has increased funding for HIV/AIDS programs from 300 to 400



Plenum



Gisela Lange

“We cannot do without civil society.”

million Euros per year, but we think that Germany's contribution should relate to the GNP.

If we use this as a yardstick, the German contribution should be at least double of what it is now.” Goldstein also pledged for more flexibility in the international patent law in order to ensure adequate access to anti-retroviral treatment for all people in need..

Olayide Akanni is the Executive Director of Journalists against AIDS Nigeria and also coordinates the African Civil Society Coalition on HIV/AIDS. Nevertheless, long-term funding mechanisms are essential in order to achieve Universal Access; many of the African States do not have the financial resources to implement national action plans. Therefore, donor countries should focus on comprehensive and sector wide approaches and also concentrate efforts to harmonise interventions. The kind of interventions made to combat HIV/AIDS are related to priorities of the respective governments and civil societies. It is very likely that sex workers, for example, will be at the sideline when Universal Access issues will be discussed at governmental level. Moreover, if a government does not regard HIV/AIDS as a priority, Universal Access will not be a reality in that country. Consequently, talking about Universal Access covers also the issue of lobbying governments to prioritise HIV/AIDS in their national health policies.

Moreover, interventions for women and children are essential towards achieving Universal Access since these groups lack access to treatment and care due to high travel expenses among others. “People who need these drugs must be able to access them. Therefore investments in the develop-

ment of new drugs and diagnostics also for co-infections such as tuberculosis must be increased rapidly. But due to patent restrictions as soon as new drugs are developed, people who need them most are the last who get them.”

Towards the end of the discussion, the majority of the panelists agreed that Universal Access requires a multi-sectoral approach. From 1986 onwards, fighting the disease concentrated on a health sector approach that was not working.

Now the trend goes to multi-sectoralism, which involves the cooperation between different ministries and enables all coordinating persons to see the fits and the linkages of their interventions and to see who has which responsibilities and tasks. “Coordination, harmonisation and multi-sectoralism go hand in hand,” as Olayide Akanni summarised .

“I am not interested in multi-sectoralism, I am not interested in this –ism and that –ism. I am interested in keeping people alive. The question is what we can do to keep people alive until they actually get access to antiretroviral treatment,” Mick Matthews (GFATM) stated when the floor was opened for questions. The panellists confirmed and clarified that Universal Access comprises a comprehensive package of prevention, diagnosis, treatment, care and supported interventions also addressing surrounding conditions, vulnerable groups as well as co-infections.

Although several commitments exist, funding commitments of the EU and G8 for achieving Universal Access have not been made yet. Political commitments must be amended with concrete operational and financial plans.

BY ANTJE MANGELSDORF, ACTION MEDEOR



Olayide Akanni



Sara Simon, Gisela Lange, Marwin Meier, Olayide Akanni and Rolf Goldstein

KEYNOTE

Universal Access and Financing Models

DR. CHRISTOPH BENN, DIRECTOR
OF EXTERNAL RELATIONS, GFATM

We are here to consider Universal Access to Prevention, Care and Treatment addressing one of the major threats to human health and well-being of our time. We are not talking about any kind of basic access to essential services. We are indeed considering access for all who need it to high quality prevention, care and treatment services not some kind of second class treatment for those who cannot afford more.

Currently for every person put on treatment there are six new infections. That is absolutely not sustainable. Our efforts to support prevention activities need to be scaled up and strengthened urgently. But I will now focus on the main challenge that is of interest to us today: the challenge of the financing of Universal Access.

Trends in AIDS funding, quadrupling from 2001

In response to both public health imperative and previously mentioned unprecedented political pressures, the HIV/AIDS pandemic has resulted in massive increases in donor assistance in recent years. The three most prominent new initiatives for this funding are the Global Fund, the World Bank programs, including primarily the Multi-country HIV/AIDS Program (MAP), and PEPFAR. According to UNAIDS, global funding to combat HIV/AIDS in low- and middle-income countries has more than quadrupled since 2001, from \$2.1 billion to an estimated \$6.1 billion in 2004, \$8.3 billion in 2005, and an estimated \$8.9 billion in 2006.

This is an unprecedented success in terms of donors' assistance mobilization, yet it is still insufficient to meet the needs for prevention and treatment of HIV/AIDS in low- and middle-income countries estimated at \$ 20-23 billion by 2010.

HIV/AIDS is an exceptional pandemic that needs an exceptional effort to be reversed. I will just recall the conclusion on the UN Human Development Report published in 2005: "the AIDS pandemic has inflicted the single greatest reversal in human development".

Is the AIDS pandemic so exceptional that it requires so much money and attention? My answer is yes, because its reversal should not be just one of many Millennium Development Goals but rather an overarching priority, a prerequisite to achieving other MDGs especially those related to health and poverty.



Dr. Christoph Benn

Once we agree on the amount needed to achieve Universal Access, the second challenge is where to find the then agreed 20 to 23 billions dollars. The primary source will continue to come from Overseas Development Assistance (ODA). So far the ten major donors (including hence the G8 countries) represented an average of 88% of the annual level of overall resources to the Global Fund. Although we are trying to diversify our source of income and reach new donors, this ratio will with no doubt remain very close to this figure. This is why this year's G8 Summit commitment is so crucial to the achievement of our goal.

Innovative Financing: Debt2Health-Initiative and UNITAID

To complement the more traditional sources of funding the Global Fund works hard to open up new, innovative funding mechanisms. The most recent one is the so called Debt2 Health-Initiative. Debt2Health is a new as well as innovative initiative where for the first time debt swaps or debt conversions are carried out through a trilateral arrangement involving a multilateral organization. Debt2Health is aimed at freeing up domestic resources through debt relief that can be invested in urgent public health needs in the fight against HIV/AIDS, TB and malaria. A feasibility study conducted by civil society organizations has shown that debt conversion has the potential to generate hundreds of millions of dollars and that it should be tested. Debt2Health is based on a Global Fund facilitated agreement under which creditors forgo repayment of a portion of their sovereign debts on the condition that the beneficiary countries invest an agreed upon counterpart amount in health through the Global Fund. To give you an example let me mention the German-Indonesian pilot case: Germany has made the offer to forgo repayment of 50 million Euro on the condition that Indonesia invests the equivalent of 25 million Euro in health through approved Global Fund programs. Debt2Health

funds are subject to Global Fund policies and are disbursed based on the normal grant management procedures. This means that the activities funded by Debt2Health are fully integrated in a country's program. After the unanimous approval of Debt2Health at the 15th Board meeting just a month ago, a pilot phase will be implemented in Indonesia, Kenya, Pakistan and Peru.

Among the innovative finance mechanisms with which the Global Fund has strengthened its engagement over the last year, is its partnership with UNITAID.

UNITAID is an international drug purchase facility financed largely by air ticket levies. Initiated by President Chirac, UNITAID was launched in September 2006 and that now gathers a group of 34 countries that have adopted or begun the process for application of a solidarity levy on airline tickets. UNITAID's mission is to contribute to the fight against the three diseases – HIV/AIDS, TB and malaria – specifically, by facilitating and broadening access to the life-saving drugs to treat them. In particular, UNITAID aims to address the specific needs of developing countries by increasing the supply and lowering the prices of drugs without compromising their quality.

UNITAID has formally approved US \$ 52.5 million as a contribution for purchasing medicines for Global Fund Round 6 grants. The Memorandum of Understanding for this agreement which is under way will include agreed drug procurement procedures, as well as details on how results to be achieved from this contribution will be monitored and reported. This preliminary approval of USD 52.5 million after a few months of existence of UNITAID and the development of cooperation with this expanding financing instrument is very promising and will with no doubt contribute actively to the achievement of Universal Access, through the provision of lower priced ARV treatments.

Private Sector Sources of Funding

One example of mobilizing financial resources from the private sector is (PRODUCT)RED, a marketing initiative launched last year by Bono and a group of global consumer brands such as American Express, Apple, Armani, Converse, Gap, and Motorola. RED has already had a significant positive impact in its first year, generating \$20 million for the Global Fund, while raising awareness of the relevance and urgency of the fight against AIDS amongst millions of consumers.

In addition to the RED campaign, I would also like to mention to essential role of private foundations as a major source of funding to achieve universal access. The Bill & Melinda Gates Foundation has already contributed USD 650 million to the Global Fund and will remain a crucial partner for the

years to come.

Being able to combine different sources of funding, from ODA, Innovative Finance and Private Sector initiatives, and with constant effort to ensure that this funding is additional and does not cannibalize the financing of other causes or partner organizations, the Global Fund is very well positioned to contribute significantly to the achievement of Universal Access.

Conclusion

At the end we have to remember: Universal Access is not about numbers and money. It is about real people. People who are faced with the most dramatic consequences of action or inaction: life or death. The paradigm shift we have seen over the last few years has not only saved millions of lives already. It has changed the way people in poor countries look at their future. I remember well the days of complete despair and fatalism when there was no treatment, no care no future. When I visit programs in Africa now, the sentiment is quite different. There is treatment for some, not all, but there is something more: there is hope. Although



Global Fund John Rae

hope is not a quantifiable indicator it is extremely important for people who are facing so many challenges and who feel that nobody cares for them.

That is also the reason why under no circumstances can we afford to betray this sense of hope. The world represented by their most prominent leaders in the UN and the G8 have made promises to achieve Universal Access. We would lose not only millions of life but any kind of credibility that might be left if the promise was not fulfilled.

Universal Access is a great challenge but also a fantastic opportunity. We need your strong advocacy and support at this G8 Summit and beyond. We cannot and we will not fail.

● PART I IS EUROPE AWARE OF ITS RESPONSIBILITY AND AFFECTEDNESS BY HIV AND AIDS?



Genet Mengistu/Felicitas Hikuum

Aspects Of Universal Access - Prevention

GENET MENGISTU, MINISTRY OF FINANCE AND ECONOMIC DEVELOPMENT (MOFED), ETHIOPIA

Universal Access is an ambiguous term. It means different things to different people and it is supposed to incorporate a lot of different aspects.

HIV/AIDS prevention is an important tool to reverse infection rates and a relevant component of Universal Access. As I work for the Ethiopian Ministry of Finance and Development, I would like to share the Ethiopian experience in terms of HIV/AIDS prevention strategies with you.

1.3 million people are living with HIV/AIDS in Ethiopia. HIV/AIDS mainly affects the most productive age group, namely young adults, whereas 75% of all transmissions result from heterosexual contacts and 10% through mother-to-child transmissions.

In 2000, the National AIDS Council was established under the chairmanship of the Ethiopian president. It involves several ministries, Faith Based Organisations (FBOs) and Civil Society Organisations (CSOs). Similar structures have been established at regional levels. Furthermore, the HIV/AIDS prevention and control office was established in 2002 to intensify the multi-sectoral collaboration among different stakeholders in the framework of the Ethiopian prevention program.

The national strategic framework for HIV/AIDS control which was adopted in 2003 identified eight intervention areas in terms of prevention:

- Information and education
- Communication

- Condom information and distribution
- Voluntary counselling
- Management of sexual transmitted infections and blood safety
- Legislation and human rights
- Surveillance and research
- Multi-sectoral approach and community empowerment

As Aids is not curable, prevention plays a very critical role in our country. In early days prevention was focused on creating awareness using media. Now the focus lies more on behavioural change which goes beyond awareness creation. People know about ways of transmission but are not changing their behaviour. Interventions have to focus on creating behavioural change, for example, by mobilising communities and using traditional grassroot-based media. In 2004, the Ethiopian Social Mobilisation Strategy was launched comprising capacity building interventions like community conversation which involve training in administration, legislation, basic health care and engrosses health station workers and other stakeholders like the schools, media, CSOs, government organisations, artists, PLWHA in order to promote discussions on prevention issues. Moreover, we address the issue of stigma and discrimination through a so called "Compassion, tolerance and sensitivity campaign".

In order to effectively respond to the need of HIV/AIDS prevention, Ethiopia has been distributing condoms and tried to enhance the coverage of Voluntary Counselling and Testing (VCT) facilities. Ethiopia started with VCT in the late 80ies. Currently 768 hospitals and health centres are providing VCT and about 50% of all health stations are already delivering this service as well.

Although we reached these efforts, we still have a long way to go with regard to the huge population and enormous negative impacts of the disease. However, we cannot hesitate to take action. On our way forward to Universal Access to comprehensive prevention we aim to:

- increase service coverage and make it accessible to all people in need, especially to the local communities
- speed up integration with health programs
- focus on family planning as a means of prevention

But comprehensive prevention programs cannot do it without the support of the international donor community. And especially Civil Society Organisations (CSOs) make an essential contribution to prevention programs. Therefore, CSOs should scale up their good practices related to HIV/AIDS prevention and enhance their linkages with governmental initiatives.

Access to Treatment, Care and Support

DR. SONJA WEINREICH, DIFAEM/
ACTION AGAINST AIDS GERMANY

According to the World Health Organisation (WHO), access comprises availability including physical, economic and socio-cultural access, a minimum standard of quality, coverage and impact. Universal Access is a goal and a vision that was not there a few years ago.

2003 the WHO launched the "3by5 Initiative", by that three million people should receive anti-retroviral treatment until 2005. Furthermore, at the United Nations General Assembly High Level Meeting on HIV/AIDS, heads of states committed themselves to achieve Universal Access to comprehensive prevention programs, treatment, care and support by 2010. The commitment to Universal Access is a major milestone on the road to achievement of the MDGs, for MDG 6 in particular. HIV/AIDS and therefore Universal Access is also linked to other development goals such as like poverty reduction, education, gender equality, child mortality and maternal health.

Moreover, the G8 Summit in Gleneagles in 2005 committed to "Universal Access to treatment by 2010". At the G8 Summit in 2007, the commitment of the G8 to achieving Universal Access must be enhanced and therefore include also prevention, care and support. There must also be a concrete action and financial plan to achieve that goal, so that commitments can be translated into action.

Access to treatment

In Africa, there were 100.000 people under anti-retroviral treatment (ART) in 2003, which is coverage of 2% of all people in need of ART. In 2006, already 1.3 million were receiving ART, covering 28% of needy people. However, there are great variations between and within countries: for example Brazil has an ART coverage of 90%; South Africa only 35%; Uganda almost 50%.

Even with a weak health infrastructure, figures show that huge efforts have been undertaken by many countries. In the case we keep on with the current pace, in 2010 4.5 million people will have access to ART in 2010, which are still less than 50% of demand. This shows, that, more efforts are needed.

680.000 children need ART in Africa, but only 13% of them have actually access to these medications. There is urgency to act, to avoid that, AIDS mortality rates among children will further increase. In the context of access to ART also the gender dimension have to be taken into account. In many



Dr. Sonja Weinreich

countries, particularly women and vulnerable groups lack access to ART.

Weak health systems, most notably laboratory and other health infrastructure, supply systems for drugs, diagnostics and other commodities, inadequate integration of HIV services into the health care system and lack of monitoring and evaluation systems, are a major barrier for achieving Universal Access to ART.

Besides that, Africa faces an enormous shortage of health workers. The WHO estimates that there are four million health workers needed worldwide. That means a need of 7-14 billion US-Dollar for the next five years for the most affected countries. Treating, training and retaining health workers must be the focus of all actions addressing the health worker shortage.

Universal Access to treatment does not only cover ART, but also treatment of co-infections. Up to 80% of all tuberculosis (TB) patients are HIV-positive. TB is the most common cause of death among people suffering from AIDS. But only 10% of TB patients are tested for HIV. HIV and AIDS as well as TB have to be addressed through comprehensive strategies.

Major challenges

A steep increase in the number of people on treatment is one of the major challenges towards reaching Universal Access. On the other hand treatment and prevention services must be scaled up in parallel. Summing it up, Universal Access to comprehensive prevention, diagnosis, treatment, care and support, encompasses treatment of opportunistic infections, material support, income generating mechanisms, nutrition, psychosocial and spiritual support, greater flexibilities of patent regulations and affordability of second-line drugs.

Social Impact of HIV and AIDS on Children and Communities in Africa

ELI NDUWAYESU, CARE, RWANDA

According to the UNICEF Report of 2005 there are more than 14 million children under the age of 15 who have lost one or both parents due to AIDS. Around 80% of these children live in Africa and it is projected that in 2010 there will be 25 million children orphaned as a result of the devastating disease.

Psycho-social Impact of HIV/AIDS on Children and Communities

Stigma and malnutrition are the major problems of people who are HIV-positive. A person who is HIV-infected is often considered a bad person. This stigmatisation often leads to resignation and depression. Besides discrimination and stigmatisation, further social impacts of HIV/AIDS are the lack of ability to work and earn money leading to inadequate nutrition and social isolation. HIV/AIDS is a poverty related disease and a complex problem. Extreme poverty increases vulnerability to HIV infection by leading to risky behaviour.



Eli Nduwayesu CARE

AIDS orphans

Every day, the number of child-headed households increases and communities cannot afford to help all of these children. In Rwanda alone, we have more than 100.000 households that are headed by children, of course not all of them are orphaned due to Aids.

But especially children orphaned by AIDS often have to face enormous difficulties:

- A 14-year old girl from Tanzania, head of a four person's household, stated: "I feel very bad being the head of the household. I cannot get food from anywhere else apart from my garden. If I cannot harvest anything from the garden I am obliged to get food from elsewhere. I am a child like others, but there is nobody who takes care of us."
- A 17-year old girl in Zimbabwe reports: "My parents died when I was ten. They left four children. Now I am the head



Eli Nduwayesu

of the household. I started selling my body in order to get food for my younger siblings. By doing this I was infected with HIV."

In order to achieve Universal Access, psycho-social support and livelihood opportunities for children orphaned by Aids and PLWHA have to be enhanced. Furthermore, empowerment of women as a strategic approach of achieving universal access will lead to strong changes. I believe that strong women get strong children. But long-term improvement of the situation of PLWHA can only result from combined efforts from the EU, G8, African governments, NGOs and communities. These efforts need to start with the acknowledgement of the various dimensions of HIV/AIDS and have in a second step to be transferred into concrete strategic plans. Political commitment is not enough; governments of industrialised and developing countries must do something to save lives. Good intentions are not good until they are put into practice.

Dealing with HIV/AIDS in the context of my work, means, taking a comprehensive approach by confronting all effects of the pandemic with their roots. Integrating HIV/AIDS interventions with nutrition and food security will improve living conditions of PLWHA. Access to food is the key for well being, that is what I believe.

In addition, addressing HIV/AIDS has to take into account Universal Access to prevention, treatment, care and support, whereas nutrition and food security should be crosscutting elements of interventions.

Moreover, clarifying the term Universal Access is the precondition for civil society organizations being able to hold the respective governments accountable. Civil society organizations particularly in the South need to develop a concrete catalogue of demands for governments how care and support for orphans and vulnerable children can be realised. Civil society must be encouraged to strengthen its role as a critical voice and extend advocacy campaigns beyond general awareness raising and service provision.

Local Production – Access to Medicine

ELOAN PINHEIRO, CHEMIST/PHARMACEUTICAL TECHNOLOGY AND PUBLIC HEALTH

In Brazil, Universal Access to ART was adopted throughout the public health system in 1996. Since then, an Advisory Committee has been revising the treatment criteria at least once a year or as frequently as needed, in order to reflect scientific developments and availability of new drugs. The respective AIDS Drugs Logistical System comprises medical distribution, diagnostic kits, and reference laboratories among others. A computerized system for logistical control of anti-retrovirals (ARVs) was also established to monitor and control patients that use first and second line drugs.

Capacities for Research and Quality Control are pre-requisites

Besides a strong public health system, an important part of providing Universal Access to medicine for HIV/AIDS-affected Brazilians is the local production of generic ARVs in the hands of public manufacturers. This allows the government to negotiate prices of patented ARVs and purchasing APIs in the international market at the lowest prices, while requiring good quality compliance.

By developing their own capacities to manufacture ARVs the countries become more independent from international pharmaceutical corporations. If you analyze the growing of the international pharmaceutical industry, you find that during the 1980ies most of them produced without patents. For this reason, the importance of strengthening research and development in order to acquire know-how for manufacturing of generics can not be overstressed. Furthermore, the analytical methodology expertise to guarantee the quality of raw material, including Active Pharmaceutical Ingredient (API) as well as final products has to be increased. Thus in Brazil, six public laboratories are in the process of compliance with Good Manufacturing Practice (GMP) accreditation by the National Regulatory Agency. Four national pharmaceutical and chemical industries were GMP accredited, in whole or in part, to produce ARV raw materials. The results of these measurements are the approvals of various generic versions of ARVs manufactured in Brazil (e.g. Zidovudine, Didanosine). Thus, price evolution dropped down to 88%, with increasing production prices are estimated to decrease further.

Patents stop knowledge transfer

However, problems constitute constraints to local production and the assurance of low prices. These typically include



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patents, whereby monopoly patent owners dictate market prices and protect products and processes by stopping knowledge transfers. This is especially true for second line drugs which are all under patent protection. In addition, so called mailbox patents constitute a legal barrier that destroy the transition period (TRIPS agreement). Moreover, incremental patents result in delayed discovery of new drugs (true inventions).

During the last World Health Assembly, Brazil has addressed one resolution that was voted on 23/05/2007 and approved in this respect. This includes the provision, upon request and in collaboration with international organisations, of technical and policy support to countries that intend to make use of the flexibilities contained in the agreement on TRIPS (Trade-related Aspects of Intellectual Property Rights) and other international agreements in order to promote access to pharmaceutical products, and to implement the Doha Ministerial Declaration (2001/2003) on the TRIPS Agreement and Public Health and other WTO instruments.

Need for non-profitable Centers of Development

However, there is still the need to take further action, which must include the establishment of an international solidarity pact in order to build a non-profitable center of development that should be located in a least developed country for producing all patented ARVs, including APIs and medicines, in a pilot industrial scale for transferring technology to the countries with a humanitarian tariff. Finally, the Doha Declaration must be strengthened in order to provide medical access and the implementation of international compulsory licenses whenever a pandemic situation or a neglected disease is involved and essential medicine is needed to save lives. So far, the private sector has not been involved in this process to increase access to essential drugs due to the lack of profits. This needs to be changed.

Local Production in Tanzania

RAMADHAN MADABIDA, TANZANIA
PHARMACEUTICAL INDUSTRIES LTD., TANZANIA

Ramadhan Madabida, Tanzania Pharmaceutical Industries LTD., Tanzania Local production of ARVs can break the cycle of dependency, reduce levels of illness and contribute to the realization of the national health policy objectives. However, the role of the private sector in the fight against HIV/AIDS has so far been neglected. It is now time for the private sector, to attain greater social responsibility and being much more involved into the process of fighting the devastating disease.

Tanzania Pharmaceutical Industries (TPI), was incorporated in 1977 as a government owned enterprise, which was privatized in 1997. 60 percent of its shareholding was sold to local Tanzanian entrepreneurs. Since then TPI underwent a re-engineering process that included the implementation of a three phase rehabilitation programme with the objectives to become a Good Manufacturing Practises (GMP) compliant that maximises capacity utilization and provides quality medicine at affordable prices. Thus, the production has been re-vitalized, quality of our products has significantly been improved and capacity utilization has been more than doubled. In addition to that, costs of production could be reduced and prices of TPI's products decreased. Besides setting up an efficient production supply chain, TPI expanded and could employ more than 100 skilled and unskilled workers that underwent a comprehensive training program.

Thereby, TPI never lost its focus on core activities such as formulating, producing and selling anti-malaria drugs and ARVs that make up more than 75% of the population's ac-



Ramadhan Madabida

te- medical needs. This was achieved by personnel, organisational and management development through viable Public Private Partnerships (PPP), joint ventures in technology transfer and networking with health research & development institutes as well as quality assurance through the development of a total quality assurance mind-set. Thereby general lessons have been learned: Entrepreneurial spirit that assumes a win-win situation should underlie PPP initiatives and thus create opportunities for investment, growth and development. In the context of TPI, various forms of PPPs are existing, ranking from joint-ventures with the Public Service Pensions Fund of the Ministry of Health, Finance, Trade and Marketing to Tanzania's Pharmaceutical Manufacturers Associations. These partnerships promoted local production of essential drugs by VAT exemptions on raw material, additional investments, import restrictions in form of charges that account 2 % of the FOB value as a service to Tanzania Food and Drug Authority (TFDA) and increased purchase of locally produced drugs by the Medical Stores Department. The World Bank partly funded laboratory equipment and drug registration fees of US\$ 100-500 per dosage resulted in increased capacities for TFDA to built own premises, self-finance procurement of working tools and initiate drug registration programs. Consequently, local companies invest heavily in upgrading facilities and putting up new ones to attain GMP status.

Nevertheless, there are several challenges on the way forward to 2015 such as:

- Establishing a drug management supply system in cooperation with the Tanzanian Ministry of Health in order to enhance public access to essential drugs
- Increasing the use of private pharmaceutical sector distribution systems
- Instituting measures that will improve quality of private



sector services supporting national health objectives and involving major stakeholders

- Development of “Accredited Drug Dispensing Outlets”

With support of action medeor, a two phase joint implementation of ARV production could be established. In a first step, former sterile production sections were converted to an antiretroviral manufacturing facility. Furthermore, training programs sponsored by InWent and action medeor on GMP, production processes and validation were provided. With the purchase of new machineries, production took off with five products in 2005. In a second phase, modular facilities that produce 80 000 to 100 000 doses should be established to up-scale and expand local production of ARVs.

Expected results of the two phase program include:

- the creation of a “learning centre” for the acquisition and dissemination of knowledge and capacity building of local and regional expertise
- creation of a “skill pool” of local expertise capable of undertaking quality domestic pharmaceutical manufacturing,
- production of affordable high quality antiretroviral drugs
- meeting at least part of the nation’s needs for ARV’s in terms of quality, quantity, affordability, accessibility and sustainability

Development of a skilful, vibrant and dynamic drug regulatory authority capable of discharging its duties effectively and efficiently TPI is faced with a variety of challenges ranging from the lack of technical and human resources and low investment capacities. The involvement of the private sector, however, can make serious contribution to combating HIV/AIDS. Capacity needs to be built within the local

communities and businesses for them to become meaningful participants in “investing at the bottom of the pyramid” (Prahald & Hart), and in the process to add value to the society. What is needed are demand-driven and inter-disciplinary interventions. It is in this vein that local production interventions are not only appropriate and timely, but also commendable.



Strengthening local capacities of ARV production supports efforts towards achieving the MDGs. In this context it is essential to embed local production projects in the national health schemes in order to avoid duplication and waste of resources. Another benefit is the provision of direct employment to local people, enhancing business and furthering indirect employment to related industries therefore contributing to the alleviation of poverty.



Penina Ochola

Orphans and Vulnerable Children - An Integrated Approach

PENINA OCHOLA, PLAN INTERNATIONAL,
REGION EAST AFRICA

The crisis for children due to HIV/AIDS will persist for decades, even though prevention and treatment programs have been expanded.

Never before in human history, had such a vast number of orphans been left with limited or even no adult protection and care. Sadly many orphans and vulnerable children are themselves living with HIV/AIDS and they are also those who have to care for their siblings and chronically ill parents, living at the same time in financially stretched households. Some of them will even engage in high risk behavior to support themselves and their families. According to numerous studies in multiple countries, orphans are more likely to suffer from poor nutrition, lack of access to basic health care, lack of education, psychological and emotional difficulties than non-orphans. We have learnt that effective care and support of these children depends upon policy and legislation, medical care, socio-economic and psychological support, education, human rights and community based programs. In addition, emphasis on community rather than institutional care is best for the child. In this context, strengthening capacities of families and communities is effective, whereas involvement of children and youth is mandatory. Sector-wide partnerships are critical, and integration of other prevention, care and support services is essential. That is why Plan International has developed a framework, called "Circle of Hope" which underlines Plan International's commitment promoting the rights of children. This framework was initiated and piloted in Uganda.

It has also guided strategies in the Pan-African partnership-HACI (Hope for African Children Initiative), which operates in nine countries of Sub-Saharan Africa. The approach aims to reduce children's vulnerability and to extend the life of parent-child relationships in families affected by HIV/AIDS. In addition, HACI support affected families to live positively and prepare for the future.

All in all, the "Circle of Hope" aims to reduce vulnerability of the children by giving them opportunities and tools to develop their own leadership, on an issue that will profoundly influence their future. It reflects their rights to define and formulate attitudes and behaviors that they believe to be important and to transmit them to the peers, parents and communities where they live. Prevention and care must relate to individual, family and community responses to prevent infections and meet the needs of those who are infected or affected by HIV.

Plan International has thus supported the establishment of community based Voluntary Counselling and Testing (VCT) outreach services, the establishment of psychosocial support groups, which include People living with HIV/AIDS (PLWHA), capacity building for peer education for in- and out-of-school-children in order to scale up behavioural change. Furthermore, youth friendly services including life skill training for youth and school clubs or anti-AIDS clubs in partnerships with health facilities and other sectors have been introduced. However, no initiative for care and support of children affected by AIDS can replace the care of their parents. Therefore, Plan International supports programs that provide treatment and care to adults living with HIV. This is done in partnership with the government and other stakeholders that provide treatment for opportunistic infections, ART (anti-retroviral therapy), nutrition, livelihood, emotional support and community mobilisation to eliminate stigma and discrimination. Plan International offers also institutional support to government health facilities to provide quality PMTCT (Prevention of Mother to Child Transmission) and ARVs (anti-retroviral drugs). Succession planning is regarded as a promising approach for increasing the extent to which HIV positive parents take action to ensure a better future for their children, particularly in terms of appointing guardians, disclosing their status and engaging their children in the discussion about their future. In countries like Uganda and Zimbabwe, Plan International has established partnerships with legal bodies to support families in writing wills, raising awareness and providing support to future guardians, and psychosocial support to families. The "Circle of Hope" supports children's rights, provides them with tools for life and gives them a voice in the fight against HIV/AIDS.

Psychosocial Care and Support for Children, Families and Communities affected by HIV/Aids in Africa

IRENE BUSCH, TERRE DES HOMMES, SWITZERLAND

To date, AIDS has orphaned around 15 million children in Sub-Saharan Africa, and the number is expected to rise. Infants in Africa may have acquired HIV infection from their mothers and often die young, without access to life-prolonging treatment. Those who escape from HIV infection do not escape the impact of the disease. They often assume adult responsibilities in their homes such as serving as caregivers to their ill parents. Older children may seek paid employment down to selling their own bodies to support their families. These children may raise their young siblings in place of their parents. If orphaned, they depend on the goodwill of others to take care of them.

Facing such economic and physical vulnerability, the psychosocial burdens of the HIV/AIDS pandemic seem less important, not so urgent and compelling. But for children the emotional demands of HIV/AIDS are heartbreaking. Up to now the psychosocial needs of children infected/ affected by HIV/AIDS are widely unmet.

Laurie Bauman and Dr. Stefan Germann state in their study about "Psychosocial Impact of the HIV/AIDS Epidemic On Children and Youth", in 2006 that:

"Despite the urgency of children's needs, society and governments have failed to acknowledge adequately children's anxiety (...) and guilt. (...), with no adult to guide them, (...) they lack the cognitive and emotional maturity and skills to cope alone. If we listen to the children, we will learn about their emotional, psychological, developmental and behavioural needs."

The former terre des hommes switzerland program coordinator and psychosocial support advisor for REPSI, Dr. Kurt Madoerin, stated that the fundamental goals of psychosocial care and support programming for children are meaningful and secure peer relationships and social ties, a sense of belonging and of self-worth, cognitive and spiritual development and physical and economic security among others. Those fundamental goals have been embedded in the terre des homes psycho-social support program that aims to give hope for the children, a rare item in the face of an affected or infected child.

Psychosocial support (PSS) needs to be part of the mainstream of public health and social responsibilities and at the same time be implemented with very specifically focused actions such as humanitarian aid. Other key programming



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areas directly or indirectly serving children affected by HIV/AIDS, poverty and conflict are: educational systems, paediatric anti-retroviral (ARV) programmes, feeding programmes, home based care programmes, early childhood development, community development and poverty reduction strategies, children and youth empowerment programmes.

Children are not the problem but part of the solution

The high burden levels on governments and communities forces them to provide selective support and PSS is viewed as a luxury even though it can be provided at relatively low costs. Lack of PSS for affected children has long term severe consequences at individual, community and social level. This could for instance lead to dysfunctional societies, breakdown of civil societies, jeopardizing years of investment in national development, loss of security and stability at national level and to economic, political and societal instability. According to the experiences and approaches of terre des hommes psycho-social support involves two different levels: On an individual (or psychological) level orphans must be enabled to tell their experience thus making it understandable and changeable.

On the social level the coping efforts of orphans must be acknowledged by the people around them.

The support which makes use of their own resources can minimize the impact of surrounding stress factors and even transform it into social energy. Experiences show, that from this point onwards, children and youth have the empowerment and ability to resume their education and start to engage in income generating projects. The needs of children affected by HIV/AIDS are essential to be considered in the framework of a comprehensive approach that combats the disease.

Female-Initiated Methods of Prevention

DR. KIM EVA DICKSON, MEDICAL OFFICER,
PREVENTION IN THE HEALTH
SECTOR, DEPARTMENT OF HIV/AIDS, WHO

According to data released by UNAIDS, in 2006, women represented 45% of HIV-infected adults worldwide and 59% are in Sub-Saharan Africa. Women are at higher risk of HIV infection than men partly because of biology, partly because of economics, and partly because of culture. There is evidence that most women get infected with HIV from their boyfriends and husbands, than from casual or commercial sex.

25 years of HIV/AIDS pandemic, we only have one proven method of HIV prevention that women can directly control. The female condom is an existing technology that is still under-utilized due to factors inhibiting accessibility, affordability and acceptability. But it is critical that the global response to HIV infection invests in making a range of prevention technologies available so that an individual woman or girl – regardless of income, age or location, religion, educational level, or social status – can access and utilize options that she feels appropriate. Lessons from family planning clearly demonstrate that having a range of choices increases utilization, and the same is likely to hold true for HIV prevention. One size does not fit all.

Given the increased attention to the impact of HIV/AIDS on women and girls and the urgent need for female-initiated and -controlled prevention methods, a robust movement to accelerate the production of emerging technologies, and enhance access to existing technologies is emerging. The international community has committed to work towards Universal Access to Prevention, Treatment, Care and Support by 2015. Part of this commitment, in paragraph 15, was to “develop with equal urgency better tools – drugs, diagnostics and prevention technologies, including vaccines and microbicides – for the future” And in paragraph 45 the nations of the world agreed to “Commit ourselves to intensifying investment in and efforts towards the research and development of new, safe and affordable HIV/AIDS-related medicines, products and technologies, such as vaccines, female-controlled methods and microbicides”.

So what is a microbicide? A microbicide is any substance that can substantially reduce the risk of acquiring or transmitting sexually transmitted infections, including HIV, when it is applied in the vagina or rectum. It's important to understand that no proven microbicides exist yet on the market. What we're talking about here are products that are still being researched.



Dr. Kim Eva Dickson

The first generation of microbicides could be available by the end of 2010. They will probably look a lot like the over-the-counter yeast infection treatments and birth control products we already know -- the gel, foam, cream and suppository-type products that have been on the shelves for years. But scientists are also working on developing new formulations that may make the second generation of microbicides even more user-friendly than today's spermicides. For example, they're working to make formulations that women can use several hours or even days before intercourse, if necessary. One possibility is a vaginal ring or sponge-- something that could slowly release the protective substance over time, providing round the clock protection.

However, it's important to remember that none of these new technological interventions – vaccines, diaphragms, microbicides, condoms, will be a magic bullet to combat the HIV/AIDS pandemic. Technology is just one piece of a comprehensive response and the Universal Access agenda. In order for women to really be able to use these technologies, we need to address the broader structural issues that make it difficult for women to insist on condoms in the first place. We need to give women more economic opportunities and social power. The international development policy highlights the urgency of developing microbicides, but the research policy sees it as just one of many areas to be funded. The annual funding of microbicides stands at only half of what is needed – collectively, the EU needs to double its annual contributions. The funding mechanisms need to be more suitable for product development over the long-term; able to deal with issues that arise rather than being tied to short-term projects. Finally, the EU needs to think more about how to build and strengthen the capacity for health and HIV prevention research in the countries which gain most from these new HIV prevention tools.

HIV/AIDS & Gender-Based Violence

JULIENNE MUNYANEZA, WACC, CANADA/RWANDA

According to the Amnesty International Report in November 2004, "The increasing spread of HIV/AIDS among women and sexual violence are interlinked. If governments are serious in their fight against the disease, they also have to deal with another worldwide "pandemic": violence against women. Over the last few years, it has become increasingly clear that violence is a key factor in women's risk of contracting the virus or violence as a result of HIV/AIDS. Following a study conducted by the Pan American Health Organization, a regional office of the WHO, there is "an increased risk of HIV/AIDS among victims of gender-based violence, but also being HIV+ is a risk factor for violence against women." More concretely, "The relationships between gender-based violence and HIV/AIDS infections are especially evident in the areas of sexual abuse of children and adolescents, sexual violence between partners, the positive relationship between sexually transmitted diseases (STDs) and domestic violence, and the reciprocal relationship between sexual violence and HIV/AIDS".

Traditional practices such as Fertile Genital Mutilation, early marriages and the practice of newly bereaved widows being "inherited" by other male relatives", increase women's exposure to the virus. The "women inheritance", consists in denying women property and inheritance rights, employment and access to finance; they are forced into dependence on men, a fact that places women in a very weak position to assert their rights and protect them from violence. Furthermore, mass rape, like it happened during the Rwandan genocide and war, drives the HIV pandemic. Moreover, the demand for virginal young women and girls by sexually active men, and HIV positive men, has increased due to the so called "virgin myth". Little girls, toddlers and even babies (especially in South Africa, India and Thailand), are often raped by HIV positive men in some countries because the myth abounds that they can cleanse themselves of the virus! Does illiteracy contribute to the spread of GBV and HIV? Most people would say no, but remember that 70% of women and girls in Sub-Saharan Africa can neither read nor write. Most of them have no or little knowledge of HIV/AIDS. They know nothing about sexual and reproductive health and rights. As a consequence, they lack awareness of measures required for self-protection from HIV/AIDS.

They are victims of ruthless, selfish and self-serving macho men. Ensuring access of young women and girls to education including awareness raising about sex, health and HIV/AIDS is really important. The more educated girls are,



Julienne Munyaneza

the more aware they are of HIV and methods of prevention, and the greater their capacity and confidence to negotiate safer sex. More educated girls marry later, have greater choice in marrying, are less dependent on men, and have a higher status within the family. Increasing girls and women's educational and employment opportunities contribute in major ways to help them achieve autonomy".

In 2001, the United Nations General Assembly Special Session on HIV/AIDS (UNGASS) acknowledged the role of violence against women in spreading HIV, and the members, including your government and mine, made a clear commitment to take action by 2005 to develop and implement national strategies for the "elimination of all forms of discrimination, as well as all forms of violence against women and girls, including harmful traditional and customary practices, abuse, rape and other forms of sexual violence, battering and trafficking in women and girls."

To fight gender-violence there is a need to:

- Train women in negotiation skills: Women in too many circumstances, especially in Africa, do not have the capacity to "say no" to unwanted sex or to negotiate monogamy with their male partners. Furthermore, women have little room to negotiate the use of condoms.
- Punish all men who rape and/or abuse children, girls as a way of getting cured of HIV.
- Ensure education for women and girls, including information about health and sexuality.
- Increase economic empowerment of women so that those who sell their bodies in order to survive or to feed their children.
- Undertake more effective public information campaigns to fight HIV/AIDS -related stigma.
- Introduce and implement methods of preventing HIV after sexual violence through HIV Post-Exposure Prophylaxis (PEP)

The role of civil society in fighting gender-based violence and HIV/AIDS?

Civil society organisations and community-based organisations are really doing a good job in the framework of disease control. And where governments have collaborated with CSOs and CBOs, their involvement has made a big difference. However, CSO's role will be crucial in the fight of HIV/AIDS regarding the following issues:

- Community mobilization for zero tolerance of gender-based violence
- Fighting stigma, hence in many parts of the world, stigma

blocks the way for women to access appropriate medical health care and leads to the exclusion of women from families or communities

● Fighting the virgin myth

Without any doubt, CSOs and CBOs should be empowered to act as watchdogs making sure that laws against gender-based violence and HIV/AIDS are enacted, funded and implemented.

However, CSOs and CBOs should make sure not to become "agents of the West" or be at risk of having their agendas labelled as driven by "foreign" donors.



Global Fund John Rae

I am not Martin Luther King Junior but I have a dream:

Imagine all the money spent on buying weapons in Africa;

imagine the billions spent on the war in Iraq and Afghanistan.

And I don't want to think about Darfur. Imagine all that money

being used to fight HIV and AIDS, to provide treatment to

all who are HIV+;

to feed the hungry and starving children;

to build hospitals and schools;

to provide drinking water to millions of people.

What a different world we would have, what a different Africa!

That's my dream.

Programme

<p>13:30</p> <p>14:00</p> <p>Part I</p> <p>14:30</p> <p>16:00</p> <p>16:30</p> <p>18:00</p> <p>Part II:</p> <p>9:00</p> <p>9:10</p> <p>10:10</p>	<ul style="list-style-type: none"> ■ Arrival and Registration of the Participants ■ Opening Remarks Christian Gramsch, Director of Programmes, DW Erich Stather, State Secretary in the Federal Ministry for Economic Cooperation and Development Bernd Pastors, Member of Board, VENRO/action medeor Is Europe Aware of its Responsibility and Affectedness by HIV and AIDS? ■ Panel Discussion Global Awareness and Responsibility Chair: Sara Simon, Care International, Brussels Olayide Akanni, Head of Journalists Against AIDS, Nigeria Marwin Meier, HIV and AIDS Coordinator, World Vision Gisela Lange, HIV and Aids Unit, German Federal Ministry of Health Dr. Rolf Goldstein, Speaker Action against AIDS Germany and HIV/AIDS Advisor misereor Coffee/Tea Break Lectures/Discussions: Aspects of Universal Access: Chair: Felicitas Hikuam, World Aids Campaign, South Africa ■ Prevention Genet Mengistu, Ministry of Finance and Economic Development (MOFED), Ethiopia ■ Access to Treatment, Care and Support Dr. Sonja Weinreich, Difäm/Action against AIDS Germany ■ Social Impact of HIV and AIDS on Children and Communities Eli Nduwayesu, CARE, Rwanda ■ Dinner and Evening Arrangement Ama Gold, Kamerun/Bremen Insights – How to Achieve Universal Access? Summary Day 1 Overview ■ Universal Access and Financing Models Dr. Christoph Benn, Director of External Relations, Global Fund to Fight AIDS, Tuberculosis and Malaria Chair: Dr. Sonja Weinreich Coffee/Tea Break 	<p>10:30</p> <p>Lectures/Discussions: Special Aspects of Universal Access: Chair: Johannes Beck, Head of DW-RADIO/Portuguese</p> <ul style="list-style-type: none"> ■ Local Production – Access in Africa Eloan Pinheiro, Chemist/Pharmaceutical Technology and Public Health, Brazil ■ Local Production in Tanzania Ramadhan Madabida, Tanzania Pharmaceutical Industries Ltd., Tanzania ■ Orphans and Vulnerable Children – an Integrated Approach Penina Ochola, Plan International, Region East Africa ■ Psycho-Social Support Related to HIV and AIDS Irene Busch, terre des hommes, Switzerland ■ Female-Initiated Methods of Prevention Dr. Kim Eva Dickson, Medical Officer, Prevention in the Health Sector, Department of HIV/AIDS, WHO ■ Gender-Based Violence Julienne Munyaneza, WACC, Canada/Rwanda <p>12:00</p> <p>13:00</p> <ul style="list-style-type: none"> ■ Working Groups 1) <i>Prevention – How Can We Make it Work?</i> 2) <i>Patent Regulation – Access to Medicines</i> 3) <i>Health Worker Crisis and Infrastructural Challenges – Approaches and Remedies</i> 4) <i>Mitigating Social Impact on Children and Communities</i> 5) <i>Sustainable Finances - Existing and Alternative Ways</i> 6) <i>HIV und AIDS on the Agenda of EU and G8 and Linkages to Other MDGs</i> <p>16:00</p> <p>FINAL DISCUSSION:</p> <ul style="list-style-type: none"> ■ Reversing HIV and AIDS till 2015: Challenges and Visions Chair: Felicitas Hikuam, World Aids Campaign, South Africa Speakers of Working Groups ■ Final Presentation and Communiqué <p>17:00</p> <p>17:30</p> <p>End of Conference</p> <p>The conference will be held in English.</p>
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Speakers

Christian Gramsch is the Director of Programmes for Deutsche Welle's radio and internet services in Germany. From 1981 to 1983 he worked as a journalist at Südwestfunk (South-West Radio) Baden-Baden. In the following years, he worked as a freelancer for various ARD stations, the radio news agency RUFA, VOX and DW-TV. From March 2000, Gramsch was editor-in-chief for Hessischer Rundfunk radio until he took over his present position in March 2006.

Dr. Erich Stather is the State Secretary in the Federal Ministry for Economic Cooperation and Development in Germany. Erich Stather studied social sciences, history and law in Freiburg and Mainz. Before obtaining his present post he was personal secretary to the Lord Mayor of Mainz (1979-83), personal secretary to the parliamentary group chairperson and press officer of the SPD parliamentary group in the state legislature of Rhineland-Palatinate (1983-89), press spokesperson of the SPD parliamentary group in the state legislature of Hessen (1989-91) and state secretary and spokesperson for the state government in Hessen (1991-93). Since 1998 Erich Stather has been holding the position as State Secretary in the Federal Ministry for Economic Co-operation and Development (BMZ).

Bernd Pastors is a Member of Board of VENRO and Executive Director of action medeor e.V. He studied Economics in Duisburg. Since 1985, Bernd Pastors has been working for the German Medical Aid Organisation action medeor. 1987 he became head of the public relations department followed by the post of the Deputy Director in 1989. In 1997 he obtained his present position.

Sara Simon is a development economist currently working as the Policy and Advocacy Coordinator for CARE International, based in Brussels. For the past two years, Sara Simon has coordinated the global advocacy work for CARE on HIV and AIDS, with a specific focus on Universal Access. Prior to working with CARE, Sara Simon worked to build the capacity of civil society in the West Bank and Gaza. The last three years she focused on Africa. She has a B.S. from Georgetown's School of Foreign Service and an M.A. from Johns Hopkins SAIS in international economics.

Marwin Meier is working as a Coordinator for HIV and AIDS at World Vision Germany. Since 2001, he has been coordinating HIV and AIDS projects in Africa, Asia and Latin America. Since 2002 Marwin Meier is engaged in advocacy work

through Action against AIDS, Germany. As of September 2007, he manages an advocacy campaign in favour of orphans and vulnerable children. He has two BAs from Andrews University, Michigan, U.S.A. and a MSc in Health Promotion from the London School of Hygiene and Tropical Medicine.

Olayide Akanni holds a Masters degree in Biochemistry from the University of Ibadan, Nigeria. Currently, she is the Acting Executive Director of Journalists against AIDS (JAAIDS) Nigeria. Over the past five years, Olayide Akanni has served in various capacities for JAAIDS and several other advocacy based coalitions including the African Civil Society Coalition and the Pan African Treatment Access Movement (PATAM) promoting HIV/AIDS and TB treatment literacy, capacity building for media and civil society groups as well as policy monitoring on universal access to prevention, treatment and care services.

Gisela Lange is the Deputy Head of the Unit Strategy of Fight against AIDS in the German Ministry of Health Department for Prevention, Health Protection and Disease Control.

Rolf Goldstein, Spokesman for Action against Aids Germany and AIDS-Expert for projects in Afrika, worked for the German Catholic Bishops' organization for development cooperation misereor for many years and is nowadays working as an independent consultant specialised on mainstreaming of HIV/AIDS in development projects.

Genet Mengistu studied Statistics (BSC) in Addis Ababa and Demography (MA) in Canberra. She joined the then National Office of Population in July 1994 and worked as the head of Reproductive Health, Women and Youth Affairs Department until May 2006. Since then, Genet Mengistu has been working as the head of Population Department of Ministry of Finance and Economic Development (MoFED) in Ethiopia with the responsibility of coordinating the implementation of the National Population Policy.

Dr. Sonja Weinreich studied medicine and social sciences and is specialised in public health. From 1995 to 2000 she worked in Lusaka, Zambia, with civil society organisations on HIV and AIDS. Since 2001, she has been HIV and AIDS advisor at the German Institute for Medical Mission (DIFAEM) in Tübingen. Weinreich is a member of the campaign council of Action Against AIDS Germany.

Eli Nduwayesu, studied Psychology (MA), Education (BA) and Administration and has been working as a community mobiliser in Rwanda specialized on psychosocial care and support to orphans and other vulnerable children/youth (OVCY). From 1995 to 1998 Eli Nduwayesu worked for the Canadian Center for International Cooperation, and then for the World Food Programme from 1999 to 2002. Since 2003 he has been working with CARE RWANDA.

Dr. Christoph Benn studied medicine and theology and is specialized on tropical medicine and public health. For several years Benn was working as executive physician at Bulungwa Lutheran Hospital and as AIDS coordinator of the Evangelical-Lutheran Church both in Tanzania. Between 1992 and 2003 he worked for DIFAEM in Tübingen, He contributed to the foundation of the Global Fund to Fight AIDS, Tuberculosis and Malaria und is currently the Director of External Relations of this organisation in Geneva.

Johannes Beck studied Regional Studies of Latin America in Cologne and Economics in Lissabon and Sao Paulo. In 1999, Beck started a traineeship at Deutsche Welle. From 2001 to 2003 Beck worked at the central editorial office for politics and economics and later at the radio editorial office for economics. Since 2006, Beck is the head of DW-Portuguese Program. Prior to this post he worked as a freelancer for professional journals and radio programmes.

Dr. Kim Eva Dickson is a Medical Officer in the HIV Department of the World Health Organisation in Geneva. Dickson is the focal person for emerging prevention technologies in the Prevention in the Health Sector (PHS) Unit of the HIV Department. Before joining the World Health Organisation she was HIV/AIDS Advisor for DFID in Nigeria. Prior to this, Dickson worked for several years as a DFID Technical Cooperation Officer seconded to the Reproductive Health and HIV Research Unit of the University of Witwatersrand, South Africa. Dickson has been involved in microbicides work since 1997 and chairs now the Global Campaign for Microbicides Steering Committee and the African Microbicides Advocacy Group Steering Committee.

Julienne Munyaneza studied Communication in Nairobi, Mainz and London. She is the World Association of Christian Communication (WACC) regional coordinator for Africa and the Middle East since 1994. Previously, she headed the communication department of the Church Council in Rwanda.

Julienne Munyaneza represents WACC in ecumenical committees as the HIV/AIDS strategy group of the "Ecumenical Advocacy Alliance" in Geneva and among others.

Eloan Pinheiro is a Chemist, Pharmaceutical Technologist and Public Health expert. She was the Executive Director of the Manguinhos Institute of Pharmaceutical Technology in Brazil, which is the official laboratory of the Brazilian Ministry of Health and produces essential drugs for the Brazilian population. In 1993, Pinheiro became the Executive Director for 10 years. In 2004-2006 she worked as a Senior Technical Advisor for the WHO. Now, after her retirement, Eloan Pinheiro is working as a consultant.

Ramadhan Madabida is the Chief Executive Officer of Tanzania Pharmaceutical Industries Ltd. (TPI). TPI is manufacturing a wide range of medicines and started ARV production in December of 2005. The company's vision is to become a center of excellence, not only in manufacturing quality and affordable medicines, but also in the acquisition of knowledge and capacity building of local and regional expertise.

Penina Ochola is the Regional Health Advisor for Plan International for the Region of Eastern and Southern Africa and holds a Post Degree in Public Health (Harvard University). She has been working for Plan since 1997, providing technical support to 13 African countries with the focus on HIV/AIDS as well as maternal and child health.. With her team of country health advisors, she developed the Circle of Hope framework which puts the child at the center of HIV programming. Previously, Penina Ochola was a public health lecturer in various colleges for health professionals for the Government of Kenya from 1972 to 1981. In 1981, she joined the African Medical and Research Foundation (AMREF) where she established and managed the Department of Primary Health Care (PHC) before starting to work with Family Health International as the Chief of Party for the Global AIDSCAP project in Tanzania.

Irene Busch is in charge of the REPSSI Regional Program, specialised on HIV and Aids at terre des homes, Switzerland. Before joining terre des homes, she had been working in the field of development cooperation for seven years. For another ten years she was working with indigenous communities in Switzerland and the US and counselled HIV and Aids at a regional Aids-care organisation.

Participants

No	NAME SURNAME	ORGANISATION
1	Charles Achaye-Odong	DW-Akademie
2	Olayide Akanni	Journalists Against AIDS (JAAIDS), Nigeria
3	Petra Aschoff	Deutsche Welthungerhilfe e.V.
4	Emma Aston	Tearfund, UK
5	Renate Bähr	Deutsche Stiftung Weltbevölkerung
6	Marc Baxmann	VENRO
7	Herbert Bedenbender	Missionshaus Bibelschule Wiedenest
8	Dr. Christoph Benn	The Global Fund to Fight AIDS, TB and Malaria, Geneva
9	Anna Bergman	Deutsche Welthungerhilfe e.V.
10	Birgit Betzelt	Photographer
11	Jochen Böhmer	Bundesministerium für wirtschaftliche ^ Zusammenarbeit und Entwicklung
12	Richard Brand	Brot für die Welt/Evangelischer Entwicklungsdienst e.V. (EED)
13	Catrin Braun	Karl Kübel Stiftung für Kind und Familie
14	A. R. Brink	Treatment Information Group, ZA
15	Viviane Brunne	Deutsche AIDS-Gesellschaft
16	Sandra Bulling	CARE International Deutschland e.V.
17	Michael Bunte	HelpAge Deutschland
18	Irene Bush	terre des hommes schweiz
19	Madeline Church	UK Consortium on AIDS and International Development
20	Christa Dammermann	terre des hommes Deutschland e.V.
21	Jean De Tassigny	Misereor
22	Birgit Dederichs-Bain	Deutsche Welthungerhilfe e.V.
23	Daniela Dick	Christen für Afrika
24	Dr. Kim Eva Dickson	World Health Organisation
25	Zacharie Dong A Nwal	
26	Dr. Carola Donner-Reichle	InWEnt
27	Ruth Duggan	Action for Global Health, tdh
28	Sven Eckholdt	Universität Maastricht, NL
29	Aurelio Floriano	Medicos do Mundo, Portugal
30	Pamela Foster	Deutsche Stiftung Weltbevölkerung, Uganda
31	Uwe Gartenschlaeger	Deutsche Welle
32	Ingrid Geissler	
33	Silke Gerdes	Staatliche Schule Gesundheitspflege W4/Hamburg
34	Rolf Goldstein	Action against AIDS Germany

No	NAME SURNAME	ORGANISATION
35	Cornelia Grade	Deutscher Entwicklungsdienst
36	Francoise Greber	DW-World
37	Gisela Grzesik	terre des hommes
38	Christine Haefele	action medeor e.V.
39	Mirjam Hageböling	Action against AIDS Germany
40	Ulrike Hanlon	Arbeitsgemeinschaft für Entwicklungshilfe e.V.
41	Ute Hedrich	Amt für Mission, Ökumene, kirchl. Welt- verantwortung/ Ev. Kirche Westfalen
42	Ronny Heintze	Aids-Hilfe-Bonn e.V.
43	Frauke Heinze	Deutscher Entwicklungsdienst
44	Felicita Hikuam	World AIDS Campaign, ZA (Namibia)
45	Olaf Hirschmann	Brot für die Welt
46	Gerbeatrice Hyder	Deutsche Welle
47	Alphonsine Kayinamura Ihunge	Isange e.V, Bonn
48	Linda Jacob	Casa-Kibera e.V., Hamburg
49	Julia Jakob	Deutsche Stiftung Weltbevölkerung
50	Isabel Kassabian	APCO Worldwide
51	Samia Kassid	Plan International Deutschland e.V.
52	David Klisch	CARE International Deutschland e.V.
53	Silke Klumb	Deutsche AIDS-Hilfe e.V.
54	Maren Kröger	Plan International Deutschland e.V.
55	Irmela Kuhlen	
56	Barbara Kühlen	action medeor e.V.
57	Barbara Küpper	Misereor
58	Anke Kurat	VENRO
59	Andreas Loebell	terre des hommes schweiz
60	Susanne Luithlen	Global Fund to Fight AIDS, TB and Malaria, Geneva
61	Ramadhan Madabida	Tanzania Pharmaceutical Industries Ltd., Tanzania
62	Allena Magombo	Coalition of Women living with HIV/AIDS, Malawi
63	Dilip Majumdar	Medical Consultant, Köln
64	Frau Majumdar	
65	Antje Mangelsdorf	action medeor e.V.
66	Mick Matthews	The Global Fund to Fight AIDS, TB and Malaria, Geneva
67	Marwin Meier	World Vision e.V. Deutschland
68	Alemu Mekdes	Deutsche Stiftung Weltbevölkerung, Ethiopia

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70	Celine Mias	International Partnership for Microbicides, DSW
71	Marion Michels	CARE International Deutschland e.V.
72	Frank Mischo	Kindernothilfe e.V.
73	Oliver Moldenhauer	Ärzte ohne Grenzen e.V.
74	Thoko Molefe	MUSA (Muthande Society for the Aged), ZA
75	Josiane Monkam	Deutsche Stiftung Weltbevölkerung, Hannover
76	Marta Monteso	Actionaid, Belgium
77	Nicole Moran	Malteser International
78	Christine Mörth	Bundesministerium für wirtschaftliche Zusammenarbeit und Entwicklung
79	Astrid Motz	terre des hommes
80	Regis Mtutu	Treatment Action Campaign (TAC), ZA
81	Julienne Munyaneza	WACC, Canada (Rwanda)
82	Dorothea Munyaneza	Singer, Rwanda
83	Elie Nduwayesu	CARE Rwanda
84	Stefan Nees	CT das Radio
85	Philippa Newis	Tearfund, UK
86	Barbara Oberhauser	DAHW
87	Paul Ochieng	Malteser International
88	Penina Ochola-Odhiambo	Plan International
89	Johanna Offe	Bundesministerium für wirtschaftliche Zusammenarbeit und Entwicklung
90	Janina Otto	Deutsche Welthungerhilfe e.V.
91	Renate Ottofrickenstein	Christen für Afrika
92	Ayla Öztürk-Banha	GI Besucherprogramm Bonn
93	Bernd Pastors	action medeor e.V.
94	Juliane Petersen	Plan International Deutschland e.V.
95	Eloan Pinheiro	Consultant, Brazil
96	Peter Potter	Medicines for Malaria Venture (MMV), Geneva
97	Dr. Michael Rabbow	Boehringer Ingelheim International GmbH
98	Dr. Piet Reijer	Missionsärztliches Institut
99	Dr. Birte Rodenberg	Action against AIDS Germany
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101	Margrit Röhm	Deutsche Welthungerhilfe e.V.

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104	Ursula Römhild	
105	Joachim Rüppel	Missionsärztliches Institut
106	Britta Rutert	DAAD - Ref. 431
107	Karin Schattenberg	Plan International Deutschland e.V.
108	Volker Schauer	Nordelbisches Missionszentrum
109	Katharina Scheffler	Deutsche Stiftung Weltbevölkerung, Hannover
110	Anna Schelnberger	World Vision e.V. Deutschland
111	Dr. Beate Scherrer	JIGSAW - Entwicklungspolitisches Servicebüro
112	Saskia Schmidt	CT das Radio
113	Ellen Schmitt	Misereor
114	Dr. Peter Schmitz	Malteser International
115	Dr. med. Klaus P. Schnellbach	GITEC Consult GmbH
116	Thomas Schwarz	CARE International Deutschland e.V.
117	Inga Seifert	action medeor e.V.
118	Julia Sievers	GTZ Bonn
119	Karolin Simon	Terre des hommes
120	Sara Simon	CARE International, Belgium
121	Petra Stephan	Kindernothilfe e.V.
122	Claudia Thallmayer	AGEZ
123	Jan Thelen	VENRO
124	Birte Thomsen	action medeor e.V.
125	Marcel van Soest	World AIDS Campaign, NL
126	Dejan von Roman	CARE International Deutschland e.V.
127	Derek Michael von Wissell	National Emergency Response Council on HIV /AIDS Swaziland
128	Astrid Walker	HelpAge International, UK
129	Richard Weaver	EU-CORD, Belgium
130	Gabriele Weigt	Behinderung und Entwicklungszusammenarbeit e.V.
131	Dr. Sonja Weinreich	Difaem/Action Against AIDS, Germany
132	Till Winkelmann	Universität Bonn
133	Andreas Wulf	medico international

Communique of the International VENRO-HIV&AIDS Conference, 23rd/24th, May, 2007

130 participants of more than 60 civil society organisations from Europe and Africa who came together for the International VENRO-Conference "Responsibilities of Governments and Civil Society in the Fight Against HIV & AIDS in Africa - The Way Forward to 2015" in Bonn, 23-24 May 2007, held within the VENRO EU Presidency Project, are deeply concerned about the ongoing expansion of HIV & AIDS in Africa, the unnecessary death of millions of children and adults, and the avoidable HIV-infections of millions of people.

We acknowledge the progress that has been made over the past years in increased funding and political commitment by the EU and G8 countries.

We are however deeply concerned that the resources available and political commitment demonstrated do not match the scope of the pandemic and the human suffering that it causes.

At the Gleneagles Summit, the G8 promised to come as close as possible to Universal Access by 2010. The Millennium Development Goals for the improvement of basic living conditions are programmed up to 2015.

The shortfall in funding for a comprehensive response to HIV & AIDS has reached 8 billion US\$ in 2007 and is expected to reach at least 10 billion US\$ per annum between 2008 and 2010. The Global Fund to Fight AIDS, Tuberculosis and Malaria which was launched by the G8 countries and endorsed by the UN at the 2001 UNGASS, has estimated its resource needs to be 6-8 billion USD\$ per year, aiming at 10 billion US\$ by the year 2010.

Funding of the global AIDS response and political commitment of governments will have to be dramatically increased if the goals of Universal Access by 2010 and the achievement of the MDGs by 2015 are to be reached.

We welcome the German government's commitment to make Africa and HIV & AIDS a focus of their EU Presidency in the first half of 2007 and to bring it onto the agenda of the G8 Summit in Heiligendamm in June 2007.

At the EU Health Ministers Conference on HIV & AIDS in Bremen in March 2007, the German Chancellor Angela Merkel said that political leaders of Europe have to take on political responsibility and that HIV & AIDS should be on the G8 agenda and the European Council agenda. She said that "we as Europeans have the responsibility to do everything possible with our wealth, our advanced economy, and a functioning civil society to address HIV & AIDS".

The German Development Cooperation Minister Ms. Wierczorek-Zeul said on 10th May 2007 in her speech at the Ger-

man Parliament that "we will keep the promises that we made, not least in Gleneagles. The G8 Summit in Heiligendamm has to send the signal that Germany and the other G8 countries are and will remain reliable partners for Africa."

The participants of this conference call on the governments of the G8 and the EU to keep the promises they have already made and to go beyond by increasing their political commitment and demonstrating greater global solidarity against AIDS.

Health is a prerequisite for development, an investment rather than costs. Health and human rights are common public goods under the responsibility and obligation of governments to make health accessible for all, especially the vulnerable and poor groups of the populations.

Without a comprehensive response to HIV & AIDS there will be no healthy societies.

In particular, at their G8 Summit in June 2007 in Heiligendamm and at the European Council Meeting in June 2007 the G8 and the EU should provide comprehensive predictable, sustainable and long-term funding based on a finance plan to achieve universal access to prevention, treatment, care and support by 2010 and to reach the MDGs by 2015, based on fair-share contributions.

Transparency and accountability about what each country committed and is implementing and an annual review are necessary to make efforts measurable.

GENERAL RECOMMENDATIONS:

- Provide support to end violence against women, strengthen women and girls and to achieve gender equity, particularly access to sexual and reproductive health services and eliminate the disproportionate burden of HIV&AIDS on women's lives
- To include civil society and non-governmental organisations in a meaningful way and acknowledge their critical role in achieving universal access and the MDGs
- Create a mechanism that regularly and systematically reviews progress on political commitments and set global targets for universal access on which we will all be held accountable by 2010

SPECIFIC RECOMMENDATIONS:

1. Prevention – How can we make it work?

1. We call upon the Heads of all EU member states to give prevention the same significance as other aspects of Universal Access and provide long-term measures to promote

the aspect of prevention in the context of Universal Access with comparable commitment as the aspects of treatment, care and support and the allocation of political will and financial resources. Women's vulnerability at all levels, one reason being poverty, remains an important issue in addressing both the transmission and prevention of HIV and therefore requires priority attention. In addition, attention should be given to the special needs of other vulnerable groups such as children, migrants, men who have sex with men, intravenous drug users, sex workers and others.

2. Greater political commitment is required in all aspects of prevention (including commitment of financial resources), and greater emphasis should be given to evidence based prevention interventions and the scale up of best practices (including but not limited to needle exchange programmes, programmes which provided tailor made testing, care, treatment and support for the needs of specific target groups, and programmes which reduce stigma and discrimination). Prevention should be mainstreamed into other poverty reduction, care and treatment programmes (including access to finance and credit, food security, and education). The overall effect should be strengthening of health systems at all levels.
3. Greater investments should be made to increase the range of prevention options, particularly female controlled methods (such as microbicides and vaccines). Access to existing methods should be expanded.
4. The concept of prevention – and therefore prevention programmes - should take into account more than only primary prevention (ie, prevention of opportunistic infections, prevention of re-infection, PMTCT, etc).

2. Patent Regulation – Access to drugs

1. Support International public institutions for research providing open access to research data and promote local production and best use of TRIPS flexibilities to improve the self-help capacities of the developing countries. Prolong special TRIPS flexibilities and restrict patents on AIDS drugs.
2. Make TRIPS flexibilities known to different actors in developing countries and support their adaptation in the national legislation. Call for collective initiatives for issuing compulsory licences to ensure their human right to health. Bilateral and regional trade agreements should not include provisions that go beyond TRIPS.

3. Put pressure on the pharmaceutical industry to reduce prices and provide access on AIDS drugs. Address the fundamental problem of high drug prices due to patent laws in the WHO Intergovernmental Working Group on Public Health, Innovation and Intellectual Property Rights.
4. Give support to a functioning distribution chain.

3. Health worker crisis

1. Accept investments in health structures including human resources. Adopt concepts of sustained support of health service structures according to evident needs versus unrealistic expectations of a transition into sustainable structural development of public services in developing countries.
2. Ensure long term funding to strengthen health systems to meet the needs of scaled up access to treatment care and support. Enable them to cover curative, preventive and managerial primary health care (PHC) functions. This needs a focus on capacity building and the preparedness to invest in human resources and posts according to need. Acknowledge the crucial support of non-professional groups like community health workers and community based organizations.
3. There is shared responsibility of the respective governments, public service commissions, local government structures and the donors to invest in improved working conditions by introducing better salary options and career opportunities in the public sector. Economize health services and integrate the private service providers but safeguarding public interest to make quality health care accessible for all groups of the society, especially the most vulnerable.
4. In reference to the South – North brain drain it is a major concern to ensure that strategies are aiming to create better working conditions in the respective countries in order to motivate qualified staff to stay rather than to limit their rights to take international job opportunities. The upcoming EU code of conduct should reflect this concern.

4. Mitigating Social Impact on Children and Communities

1. We demand to the EU by 2010 on the basis of the UN-Convention of the Rights of the Child to:
 - Strengthen local coping mechanisms including psychosocial support of children, families and communities affected by HIV & AIDS
 - Involve children at all levels and empower them to demand their rights

- Give special focus on orphaned and vulnerable children (OVC) and child headed households
- 2. That the European Union commits itself to earmark at least 15 percent of HIV program expenditures for the treatment, care, and support of children affected by HIV.
- 3. That the European Union endorse the goals and targets of the "Unite for Children, Unite Against AIDS" campaign spearheaded by UNICEF, specifically:
 - Research on paediatric formulations including PMTCT and access
 - By 2010, increase access to antiretroviral treatment and cotrimoxazole to 80 per cent of children in need
 - For prevention of HIV infection among adolescents and young people: By 2010, reduce the percentage of young people living with HIV by 25 per cent globally.

5. Sustainable Finances – Existing and Alternative Ways

In order to achieve the MDGs – and specifically MDG6 to halt and reverse the spread of HIV & AIDS through Universal Access – predictable and long-term funding streams are necessary. Existing funding is insufficient, ad-hoc and unreliable. Therefore we make the following demands:

1. That the European Union sets annual targets for the already existing EU commitment to ODA growth so that all

member states will reach the agreed minimum-levels by 2010 (0,51% of annual GNI) and 2015 (0,7%) and the adequate proportions go to least-developed countries and to strengthening health systems.

2. That the EU member countries at the up-coming G8-Summit, namely Italy, UK, France and Germany, call for the other G7 Members to make a similar commitment to reach the UN-target of 0,7% ODA/GNI by 2015.
3. That the EU Member states commit adequate resources to support an internationally agreed funding plan to achieve Universal Access by 2010. This should include specific resource commitments based on fair share contributions and ensure predictable and sustainable AIDS-funding to multilateral and bilateral donor mechanisms such as The Global Fund to fight AIDS, Tuberculosis and Malaria.
4. That the EU recommends in an official document the establishment of taxes on common goods or international transactions as a just and effective way of increasing funding for development in general and HIV & AIDS specifically and that the European Union actively lobbies its member-states to explore and implement alternative ways of adequately resourcing HIV & AIDS activities, such as UNITAID and the Debt2Health Initiative of The Global Fund.

VENRO Members

action medeor – Deutsches Medikamenten-Hilfswerk • ADRA – Adventistische Entwicklungs- und Katastrophenhilfe • Ärzte der Welt • Ärzte für die Dritte Welt • Ärzte ohne Grenzen * • AeJ – Arbeitsgemeinschaft der Evangelischen Jugend • AGEE – Arbeitsgemeinschaft Entwicklungsethnologie • AGEH – Arbeitsgemeinschaft für Entwicklungshilfe • agl – Arbeitsgemeinschaft der Eine-Welt Landesnetzwerke • Akademie Klausenhof • Aktion Canchanabury • Andheri-Hilfe Bonn • Arbeiter Samariter Bund Deutschland • AWO International • AT-Verband * • BDKJ – Bund der Deutschen Katholischen Jugend • Behinderung und Entwicklungszusammenarbeit* • BEI – Bündnis Entwicklungspolitischer Initiativen • Bundesvereinigung Lebenshilfe für Menschen mit geistiger Behinderung • Brot für die Welt • CARE International Deutschland • Casa Alianza Kinderhilfe Guatemala • CCF Kinderhilfswerk • Christliche Initiative Romero • Christoffel-Blindenmission • DEAB – Dachverband entwicklungspolitischer Aktionsgruppen in Baden-Württemberg • DESWOS – Deutsche Entwicklungshilfe für soziales Wohnungs- und Siedlungswesen • Deutsche Kommission Justitia et Pax • Deutsche Lepra- und Tuberkulosehilfe • Deutsche Stiftung Weltbevölkerung • Deutsche Welthungerhilfe • Deutscher Caritasverband – Caritas International • Deutscher Paritätischer Wohlfahrtsverband AK „Parität International“ • Deutsches Blindenhilfswerk • Deutsches Komitee Katastrophenvorsorge • Deutsches Rotes Kreuz – Generalsekretariat* • DGB-Bildungswerk – Nord-Süd-Netz • Die Lichtbrücke • Dritte Welt JournalistInnen Netz • EED – Evangelischer Entwicklungsdienst • Eine Welt Netz NRW • Eine Welt Netzwerk Hamburg • EIRENE – Internationaler Christlicher Friedensdienst • Evangelische Akademien in Deutschland • FIAN Deutschland • Gemeinschaft Sant Egidio • Germanwatch Nord-Süd-Initiative • GSE – Gesellschaft für solidarische Entwicklungszusammenarbeit • Handicap International • HelpAge Deutschland e.V. • Hildesheimer Blindenmission e.V. • Hilfswerk der deutschen Lions • ILD – Internationaler Landvolkdienst der KLB • Indienhilfe Herrsching • INKOTA – Ökumenisches Netzwerk • Internationaler Hilfsfonds • Internationaler Verband Westfälischer Kinderdörfer • Johanniter-Unfall-Hilfe – Johanniter International • Jugend Dritte Welt • Kairos Europa – Unterwegs zu einem Europa für Gerechtigkeit • Karl Kübel Stiftung für Kind und Familie • KATE – Kontaktstelle für Umwelt und Entwicklung – Berlin • Kindernothilfe • Lateinamerika-Zentrum • Malteser International • Marie-Schlei-Verein • mterra – Stiftung Frau und Gesundheit • medica mondiale • medico international • Misereor Bischöfliches Hilfswerk • Missionszentrale der Franziskaner • Nationaler Geistiger Rat der Bahà'i in Deutschland • NETZ – Partnerschaft für Entwicklung und Gerechtigkeit • ÖEiW – Ökumenische Initiative Eine Welt • OIKOS Eine Welt • ORT Deutschland • Oxfam Deutschland • Peter-Hesse-Stiftung – Solidarität in Partnerschaft für eine Welt in Vielfalt • Plan International Deutschland e.V. • Rhein-Donau-Stiftung • Rotary Deutschland Gemeindedienst * • Senegalthilfe-Verein • SES – Senior Experten Service • SID – Society for International Development • SODI – Solidaritätsdienst International • Sozial- und Entwicklungshilfe des Kolpingwerkes • Stiftung Entwicklung und Frieden • Stiftung Nord-Süd-Brücken • Susila Dharma – Soziale Dienste • Terra Tech – Förderprojekte Dritte Welt • terre des hommes Bundesrepublik Deutschland • Tierärzte ohne Grenzen • TransFair – Verein zur Förderung des Fairen Handels mit der „Dritten Welt“ • VEN – Verband Entwicklungspolitik Niedersachsen • VENROB – Verbund entwicklungspolitischer Nichtregierungsorganisationen Brandenburgs • Weltfriedensdienst • Welthaus Bielefeld • Weltladen-Dachverband • Weltnotwerk der KAB Westdeutschlands • Werkhof Darmstadt • Werkstatt Ökonomie • World Vision Deutschland • W. P. Schmitz Stiftung • WUS – World University Service – Deutsches Komitee • Zukunftsstiftung Entwicklungshilfe bei der GLS Treuhand e.V.

*) Guest members

VENRO, the Association of German development non-governmental organisations (NGOs), is the umbrella organisation of independent and church-related NGOs working in the fields of development cooperation, emergency relief, development education, and advocacy. Currently, VENRO has more than 100 member organisations. In addition to the member organisations, about 2 000 local initiatives and small NGOs are represented in VENRO through regional NGO networks.

The association aims at strengthening the work of NGOs towards poverty eradication, the realisation of human rights and the conservation of natural resources. VENRO

- represents the common interests and positions of the member organisations vis-à-vis the public, the government, the European Commission and other international organisations,
- strengthens the role of NGOs and civil society in development cooperation,
- engages in advocacy for the interests of developing countries and poor sections of society,
- raises public awareness of development cooperation issues.

**VENRO – Verband Entwicklungspolitik deutscher
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Organisers

