

Ten civil society priorities for action now!

For endorsements please write to: HLM2016@icaso.org before May 15 2016

Too soon to declare victory: the “end of the AIDS epidemic” may be within reach, but it will slip through our fingers if we do not reprioritize now.

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- I. **LEAVE NO ONE BEHIND.** To uphold the promise of Agenda 2030 and the Sustainable Development Goals (SDGs), Member States must recognize and address the fact that key populations, including people who inject drugs, gay men and other men who have sex with men, bisexual people, transgender people, male, female and transgender sex workers, and young women and adolescents, are the groups most at risk for HIV. It also means a permanent commitment to collecting age- and sex-disaggregated data, including information about groups that are often invisible to data collectors. This requires close collaboration and regular consultation with community members to ensure that data is safely collected, using human rights metrics, and that it captures the diversity of communities affected by HIV.
- II. **PROTECT AND UPHOLD HUMAN RIGHTS:** All Member States must eliminate discriminatory laws, policies and practices, adversely affecting people living with HIV, gay men and other men who have sex with men, sex workers, people who inject drugs, transgender people, and women and girls, while ensuring human rights are upheld and protected, including the right to health. Along with multilateral financial institutions, all member states must also support action to address human rights abuses, including gender-based violence (including sexual violence) and discrimination and stigma. To do this effectively, they must invest in human rights interventions. The risk of inaction is a failure to achieve healthy lives (SDG 3).
- III. **DECRIMINALIZE HIV TRANSMISSION, EXPOSURE AND NON-DISCLOSURE:** To achieve healthy lives (SDG 3) and access to justice (SDG 16) Member States must eliminate draconian laws directed at people living with HIV. Such laws have no public health value whatsoever. Member States must also eliminate the unjust application of criminal law on the sole basis of HIV status and discrimination against people living with and vulnerable to HIV, in line with SDG 16. National governments should ensure access to justice for all. The risk of inaction is a renewed epidemic among the groups who are most at risk of contracting HIV.
- IV. **ENSURE TREATMENT ACCESS NOW:** Access to treatment, care and support, particularly among key populations (SDG 3) is a staple element of the response. Member States, with the support of donors, international organizations and the UN, must ensure that all people living with HIV needing and wanting treatment are able to receive it. In addition, Member States must ensure that access to treatment in developing countries is consistent with the World Trade Organization Declaration on TRIPS and Public Health (Doha Declaration).

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- V. **REVIVE THE PREVENTION REVOLUTION:** Prevention must remain central to all HIV responses. Combination HIV programs include a full range of complementary, acceptable, accessible, high-quality bio-medical (e.g., condoms, pre and post exposure prophylaxis – PrEP and PEP and voluntary medical male circumcision (VMMC)), behavioral, community, social, and structural interventions. HIV-related programs should meaningfully involve communities at all levels, be well managed with sufficient capacity, scaled up to reach at least 90% of those in need, be well managed with sufficient capacity, scaled up to reach at least 90% of those in need and be aligned with global guidance developed and supported by the WHO and UNAIDS.
- VI. **ACHIEVE GENDER EQUALITY:** Gender inequality and violence heighten vulnerability to HIV. Member States must commit to meaningfully addressing gender inequality (SDG 5) and gender-based violence across all levels of the response. All Member States must ensure greater and more effective linkages between sexual and reproductive health (SRH) and HIV service. SRH services should be fully funded and include programs for caregivers of family members living with HIV, the majority of whom are women and girls. SRH programs should also address gender-based violence and be tailored to the needs of key populations, including transgender women. Responses should be evidence-informed and be ready to address emerging issues, such as cervical cancer, HPV, and gender-specific presentation of tuberculosis and malaria.
- VII. **RECOGNIZE AND RESPOND TO HIV AMONG SOCIALLY MARGINALIZED GROUPS:** Member States must align their HIV response with reliably and systematically collected epidemiological data. This includes understanding disproportionate disease burden and disparities among young women and girls (SDG 5), particularly in Sub-Saharan Africa, and concentrated epidemics among gay men and other men who have sex with men, sex workers, transgender woman, and people who inject drugs (SDG 10). National AIDS programs should address the specific and differential needs of young people and people living with HIV who are aging (complementing SDG 3).
- VIII. **FULLY FINANCE A COMPREHENSIVE HIV RESPONSE:** We must ensure that resources match need.¹ Member states, donors, the international community and the UN must reenergize strained funding sources (SDG 17). The UNAIDS Fast Track goals have laid out an ambitious target of ending the AIDS epidemic by 2030 – but this plan will be little more than rhetoric without creative thinking and bold action to scale up and sustain the investments required. Stakeholders in the field of public health and thought leaders and partners in financing and development should work in close partnership. Middle-income countries should develop and implement costed transition plans as international donors, including the Global Fund, withdraw their support. Without an all-hands-on-deck effort, the moment to end the HIV

¹ UNAIDS has calculated that US\$ 31.3 billion are needed in 2020 to reach the UNAIDS 2020 fast track targets. At current levels, this means a gap of US\$ 9 billion globally.

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- epidemic will pass. This must include enabling legal and policy environments to allow for contracting between governments and community-based organizations (social contracting). National government should firmly commitment to continuing services for key populations previously supported by external donors. Donor governments and multilateral organizations should continue funding advocacy and monitoring activities to ensure responsible transition planning.
- IX. **SUPPORT COMMUNITY RESPONSES:** Funding must reach communities. Community health services, community mobilization and community monitoring play key roles in the HIV response. All Member States and multilateral funding institutions must place particular emphasis on closing resource gaps and fully fund community engagement and mobilization. Action must include quantifying, costing, and funding community-driven responses, including involvement of faith-based organizations. While anchoring services within the community is essential, governments should not offload their responsibility onto communities without ensuring adequate human and financial resources. Member States must commit to supporting strong community engagement, including resources and recognition.
- X. **ESTABLISH STRONG ACCOUNTABILITY MECHANISMS TO ENSURE COMMITMENTS ARE MET.** All member states must commit to supporting robust accountability mechanisms to ensure that the commitments made in this 2016 AIDS Declaration are translated into effective AIDS responses. They must also commit to periodic and inclusive reviews and reporting of progress towards meeting the targets set, with the full and meaningful involvement of civil society, in particular people living with HIV and key populations.

Slogans and simple answers will not end the AIDS epidemic. Efficiencies in health service delivery will **not** get us there alone. Political leaders at the community, national, regional and global levels must recommit to take real steps to end AIDS. This means using a human rights approach to:

- a. Address punitive policies and practices that prevent people vulnerable to, at risk of and living with HIV from receiving the health, legal and social services they need;
- b. Eliminate laws that criminalize HIV transmission, exposure and non-disclosure, homosexuality, gender non-conformity, sex work, and drug use; and
- c. Challenge trade and aid policies that hamper HIV commodity production, purchasing and distribution systems.

The diversity of today's HIV epidemics demands diverse, rights-based and gender-transformative responses. However, while this has long been part of the HIV lexicon, many countries and communities have not yet fully acknowledged or adopted such rights-based and gender-transformative laws, strategies, policies and programs.

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Comprehensive approaches to HIV are not new, but the global community, national governments, international organizations and donors have not yet put them at the center of HIV and health responses. Most notably, **human rights, gender equality, treatment for all, combination prevention and increased financing must anchor HIV responses**. Not all countries, communities or groups experience the epidemic equally. In some countries, HIV is “urbanized” and heavily concentrated within cities, and further concentrated among particular groups, such as men who have sex with men, sex workers, people who use drugs, people in prison, young women and girls, and transgender people. In other places, the HIV rate is growing among groups living in areas with little access to health, social and legal services, as well as among groups on the move, particularly relevant in light of the current massive humanitarian emergencies (refugees, asylum seekers, and internally displaced people).² In yet other contexts, HIV-TB co-infection is a growing cause of illness and death.³

Following the evidence, each country must *localize* and tailor its HIV response. This means they must address structural and political determinants of HIV and health inequity. Among these determinants are punitive laws and policies that criminalize people living with HIV, gay men and other men who have sex with men, sex workers, transgender people, people who use drugs, and women and girls. Also vulnerable are migrants, people in prison, people with disabilities and indigenous peoples. Governments should have policies in place to redress discrimination based on race, ethnicity, tribe, gender, gender identity, sexual orientation, language, and age. For countries where HIV is on the rise, such attention is urgent. **The risk of inaction is great: more failed policies, inadequate programmes, downward pressure on national economies and lost resources—and most importantly of all, lost lives.**

² (20151026_PCB37_EXDreport_en), at p.6.

³ For more information, please see <http://www.cdc.gov/tb/topic/tbhivcoinfection/default.htm>; <https://www.usaid.gov/news-information/factsheets/twin-epidemics-hiv-and-tb-co-infection>; and <http://journals.plos.org/plospathogens/article?id=10.1371/journal.ppat.1002464>.

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- I. **LEAVE NO ONE BEHIND.** In the context of HIV, leaving no one behind requires that member states recognize and address the fact that key populations, including people who use drugs, gay men and other men who have sex with men, bisexual people, transgender people, male, female and transgender sex workers, and young women and adolescents, are the groups most at risk of HIV. **The risk of inaction = no end in sight for the HIV epidemic.**

It also means a permanent commitment to collecting age- and sex-disaggregated data, including information about groups that are often invisible to data collectors. This requires close collaboration and regular consultation with community members to ensure that data is safely collected, using human rights and gender metrics, and that it captures the diversity of communities affected by HIV.

- II. **PROTECT AND UPHOLD HUMAN RIGHTS: All member states must commit to a human rights based approach to the HIV response that respects, protects, promotes and fulfils sexual and reproductive health and rights and eliminates discriminatory laws, policies, and practices.** This requires specific attention to repealing laws, policies and practices that increase HIV risk and those that discriminate against key populations and fail to protect women and girls, because such laws, policies and practices render services inaccessible and unaffordable. Along with multilateral financial institutions, all member states must also support action to address human rights abuses, including gender-based violence, sexual violence, discrimination, stigma and human rights violations in healthcare settings. These actions are essential to achieving healthy lives (SDG 3).

Today, unaddressed HIV epidemics among these groups threaten to undermine gains made to date in reaching global HIV targets unless countered with evidence-informed and human rights affirming interventions at scale. Moreover, concentrated HIV epidemics in these groups continue in many countries -- both high and low-income—and in countries with generalized epidemics. Access to treatment, to rights-based sexual and reproductive health programs and to legal services is often undermined by punitive laws, counterproductive policies, human rights abuses, and violence fueling stigma, discrimination and persistent disparities.

Women and girls carry a significant burden of HIV both as women living with HIV and as the primary caretakers for family and community members living with HIV. In many Eastern and Southern Africa countries, women and girls are contracting HIV two to five times more than men and boys of the same age.⁴ Action to address gender inequality everywhere in the world is a central element to effective HIV responses (SDG 5). **The risk of inaction is severe – continued growth of HIV, especially among people who face discrimination and inequality.** Targeted attention to marginalized people and communities, such as indigenous peoples, people with disabilities, migrants, prisoners/people deprived of their liberty, and other who face criminalization because of their sexual orientation, gender identity or because they are sex workers or people who use drugs is always essential to effective strategies, policies and programs.

- III. **DECRIMINALIZE HIV TRANSMISSION, EXPOSURE AND NON-DISCLOSURE: To achieve healthy lives (SDG 3) and access to justice (SDG 16)** member states must eliminate the

⁴ See UNAIDS Gap Report, 2014

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unjust application of criminal law solely on the basis of HIV status and end discrimination against people living with and vulnerable to HIV, in line with SDG 16. **The risk of inaction is a renewed epidemic among the groups who are most at risk of contracting HIV.**

All member states must eliminate punitive laws and policies that criminalize people living with and affected by HIV. If not, people living with HIV will continue to be prevented from taking advantage of the full range of services that are available and the treatment gaps will continue unabated. Such laws and policies also hamper the growth of fully integrated HIV and SRH services, as well as other forms of integrated services and harm reduction programs.⁵

All member states must also eliminate punitive laws that criminalize people because of their sexual orientation, drug use, gender identity, refugee or migrant status or their work as sex workers. If not, criminalization will continue to prevent safe, unfettered access to services as well as access to justice and remedies for violations of rights.

- IV. ENSURE TREATMENT ACCESS NOW: Access to treatment, care and support, particularly among key populations (SDG 3) is a staple element of the response.** However, member states still delay ensuring that all adults, adolescents and children needing and wanting treatment are able to receive it. **The risk of inaction is a rise in HIV among those communities for whom treatment is inaccessible and continued preventable mortality and morbidity.**

Member states should commit to time-bound treatment (ARV) scale-up goals. The pace of increasing access to ARVs will have a direct correlation with achieving reduced morbidity, reduce death, and fewer new infections, including reaching more than 30 million people with life-saving ART by 2020 and increasing the number of new people on ART by 20% on an annual basis. Access to treatment must align with new WHO recommendations. Additionally, member states must ensure that access to treatment in developing countries is consistent with the World Trade Organization Declaration on TRIPS and Public Health (Doha Declaration)

To be successful, member states must commit to scaling-up of essential adherence support pillars, such as provision of routine viral load, ART-friendly strategies including differentiated models of care and flexible refill schedules, and adherence counseling, including ensuring health workers are adequately trained, paid, and supported. In addition to ART scale-up, member states should commit to qualitative as well as quantitative indicators that reflect scale-up HIV services, improve linkages, increase support for adherence, and disaggregate data (by age, gender, and key population). Further, member states must meet the 90-90-90 targets for children and ensure that children living with HIV are on treatment, receiving holistic care and virally suppressed.

Furthermore, member states must expand efforts to combat tuberculosis, which is the leading cause of death among people living with HIV, by improving tuberculosis screening, prevention, access to diagnosis and treatment for all forms of tuberculosis including drug-resistant tuberculosis, and access to antiretroviral therapy, through more integrated delivery of HIV and tuberculosis services in line with the

⁵ For more detail, please see <http://www.cdc.gov/hiv/policies/law/states/exposure.html>;
http://www.unaids.org/sites/default/files/media_asset/jc1601_policy_brief_criminalization_long_en.pdf

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Global Plan to End TB 2016–2020, and commit by 2030 to work towards reducing tuberculosis deaths among people living with HIV by 90 per cent.

III. REVIVE THE PREVENTION REVOLUTION: Prevention must remain as a central part of all HIV responses with the strong participation of communities. Member states must be clear that they see prevention as a priority, along with treatment, care and support services, and act upon this recognition. **The risk of inaction is continued high numbers of new infections, a continued separation of treatment and prevention, further frustrating efforts toward a comprehensive response, and making treatment unaffordable.**

Bio-medical and treatment-focused solutions remain important, but a sustainable prevention framework needs to include structural and behavioural approaches, too. HIV prevention is a right. All member states must tailor prevention services to key populations and other groups that face discrimination, marginalization and gender inequality, with the strong participation and engagement of communities. In the case of those at risk of acquiring HIV through sexual transmission, this needs to include condoms, PrEP and VMMC. Furthermore, for people who inject drugs, this must include harm reduction, both through needle & syringe programmes and opioid substitution therapy (OST).⁶ Governments, with the support of donors, the international organizations and the UN must also complete the unfinished work of the *Global Plan Towards the Elimination of New HIV Infections Among Children by 2015 and Keeping Parents Alive*.

The best chance for meaningful change is delivering rights- and evidence-based, inclusive, prevention programs to those who most need them. Dismantling barriers to access in laws and policies, as a result of stigma, fear of reprisal, discrimination or gender inequality, setting ambitious prevention program targets and implementing programs at scale could bring sustainable progress within reach. Governments must accelerate their progress by taking advantage of new evidence and technologies, such as access to medical male circumcision and increased distribution of pre-exposure prophylaxis (PrEP).

IV. REVIVE THE PREVENTION REVOLUTION: Prevention must remain as a central part of all HIV responses with the strong participation of communities. Member states must be clear that they see prevention as a priority, along with treatment, care and support services, and act upon this recognition. **The risk of inaction is continued high numbers of new infections, and a continued separation of treatment and prevention, further frustrating efforts toward a comprehensive response, and making treatment unaffordable.**

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⁶ For more information, please see <http://inpud.net/en/women-who-use-drugs-and-hiv>.

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- V. ACHIEVE FOR GENDER EQUALITY:** Robust evidence shows the relationship between gender inequality and HIV. Member States must commit meaningfully to address gender inequality (SDG 5) and gender-based violence across all levels of the response. **The risk of inaction is the continued disproportionate burden of HIV on women and girls, especially women and girls living with HIV, and as members of key populations with distinct health needs, including during and after pregnancy.**

All member states must ensure greater and more effective linkages and increased support for work that connects SRH and HIV programming as well as GBV and HIV programming, as well as robust support for caregivers caring for family members living with HIV, the majority of whom are women and girls. Responses must also respect and promote sexual reproductive health and rights, involve research and evidence-informed programming on emerging issues such as cervical cancer, HPV, and gender-specific presentation of tuberculosis and malaria. Maternal mortality disproportionately impacts women living with HIV. Although improvements in health facilities and medical treatments have cut maternal mortality rates by almost half in the past twenty years, maternal deaths caused by HIV have not seen similar reductions.⁸ Worryingly, maternal mortality rates during this period have in fact increased in eight high HIV-prevalence countries in sub-Saharan Africa.⁹

Member states must recognize and address the large HIV disease burden that is shouldered by young women and girls, particularly in Eastern and Southern Africa, and transgender women everywhere. Member states must also address gender-based determinants of these disparities, including the damage caused by gender-based violence and harmful gender norms.

- VI. RECOGNIZE AND RESPOND TO HIV AMONG SOCIALLY MARGINALIZED GROUPS:** Member states must allocate resources to reflect changing HIV contexts, including: the concentration of the epidemic among young women and girls (SDG 5) particularly in Sub-Saharan Africa and among key populations (SDG 10), and the generational shift of the epidemic (complementing SDG 3). **This risk of inaction is clear: continued or accelerated flourishing of HIV in conditions of growing inequality.**

⁸ World Health Organization, Trends in Maternal Mortality: 1990 to 2013 Estimates by WHO, UNICEF, UNFPA, The World Bank and the United Nations Population Division (2014), available at: http://apps.who.int/iris/bitstream/10665/112682/2/9789241507226_eng.pdf?ua=1 (45% decrease in maternal mortality from 1990 to 2013). Coceka Mnyani, et al., *A 15-year review of maternal deaths in a background of changing HIV management guidelines*. 21st Conference on Retroviruses and Opportunistic Infections, Boston, abstract 67, 2014 (there has been no change in the proportion of maternal deaths caused by HIV since 2007).

⁹ WHO, UNICEF. Accountability for maternal, newborn and child survival: The 2013 Update. Geneva: WHO; 2013.

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All countries must ensure access to prevention, treatment, care and support programming for the full range of people living with and affected by HIV, from the very young to the very old. Each member state must reorganize its national response to reflect the changing face of HIV and recalibrate their response to prevention, treatment, care and support as a lifecycle approach. If not, HIV will continue to rise in especially vulnerable to hard-to-reach communities, such as young women and adolescent girls, migrants, and prisoners/people deprived of their liberty, among others.

Specifically, member states must recognize and increase the participation of young people and children living with HIV in decision-making processes. Young people must be directly involved in designing, implementing, providing, and monitoring services intended to meet their needs. With respect to people who are aging, greater integration within health systems and services to address multi-morbidity and the link between HIV and non-communicable diseases are needed. Regarding young children and adolescents, the response must afford substantially more attention to pediatric and adolescent testing and treatment, including treatment adherence, which can only be achieved by a comprehensive social protection, care, support and child protection.

In addition, middle income and upper middle income countries should have in place costed transition plans to ensure that treatment, prevention, care and support programs are not compromised as donors such as the Global Fund to Fight AIDS, Tuberculosis and Malaria, and many donor governments withdraw. This must include enabling legal and policy environments to allow for contracting between governments and civil society (social contracting) and commitments to continue services for key populations previously supported by external donors. Donor governments and multilateral organizations should continue funding programs and services that national HIV responses are unlikely to absorb, such as monitoring and advocacy to ensure responsible transition planning.

VII. FULLY FINANCE A COMPREHENSIVE HIV RESPONSE: It is high time to ensure that resources match need.¹⁰ Member states, donors, the international community and the UN must reenergize strained funding sources (SDG 17). **The risk of inaction is an inexcusable global failure to end the HIV epidemic, despite possessing the knowledge, technology and skills to do so.**

Countries of all income levels must receive the financial support they need to sustain the gains made thus far in combatting HIV and AIDS. Donors, the international community, the UN and member states should allocate support based on evidence about who is most at risk and most affected, for prevention, treatment and human rights programs. If not, the moment to end the HIV epidemic will be delayed or lost. UNAIDS estimates that about a quarter of a fully funded global response need to be allocated to prevention and half to treatment, if global targets are to be achieved.

The UNAIDS Fast Track goals lay out the ambitious target of ending the AIDS epidemic by 2030 – but this plan will be little more than rhetoric without creative thinking and bold action to scale up and sustain the investments required. We need collective action – now - not only from stakeholders in the field of public health, but with joint action from thought leaders and partners in financing and development. Without an all-hands-on-deck effort, this moment for action will dissipate without the requisite scaled-up action.

¹⁰ UNAIDS has calculated that US\$ 31.3 billion are needed in 2020 to reach the UNAIDS 2020 fast track targets. At current levels, this means a gap of US\$ 9 billion globally.

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Such efforts must also support financing for research and innovation. Member states should direct increased human and financial resources to new and emerging technologies, such as: multi-purpose technologies (MPTs) that enable women to simultaneously prevent pregnancy and sexually transmitted infections, including HIV; second and third-line ARVs; and rights-protective distribution of PrEP. Greater impetus to innovation also comes from implementation research, which helps to ensure that we gather lessons about what works and what does not, and participatory research and data analysis to help us better understand and address the social, structural, and political drivers of HIV.

- VIII. SUPPORT COMMUNITY RESPONSES: Re-energized funding sources must reach communities in order to ensure that community health services, community mobilization, community monitoring and community care, support & child protection services can play a key role in the HIV response.** Member states must commit to supporting strong community responses with resources and recognition. **The risk of inaction is sacrificing the chance to make the greatest strides at the most fundamental level.**¹¹

All member states and multilateral funding institutions must place particular attention to the resource gap in funding community action and activism. Action must include funding community-driven responses, including involvement of faith-based organizations, with a caveat. While anchoring services within the community is essential, governments must not offload their responsibility onto communities without ensuring adequate human and financial resources.

Member states, donors, the international community and the UN must increase support to community organizations, in order to improve service provision, advocacy, engagement, and monitoring of health responses, including through the utilization of TRIPS flexibilities. If not, communities will continue to struggle to obtain funding for their most basic needs, and HIV programming will remain inadequate.

- IX. ESTABLISH STRONG ACCOUNTABILITY MECHANISMS TO ENSURE COMMITMENTS ARE MET: Establish ways to monitor and evaluate if global and national responses are meeting their commitments.** The call from organizations of people living with HIV of “nothing for us without us” has long been a pillar of accountability for the global HIV community. Member states must commit to ensuring stronger accountability mechanisms, with an emphasis on community-based monitoring, advocacy and mobilization should accompany sufficient funding. **This risk of inaction is leaving the most marginalized and at risk behind.**

All member states must commit to supporting robust accountability mechanisms to ensure that they translate commitments made in this 2016 AIDS Declaration are translated into effective AIDS responses. They must also commit to periodic and inclusive reviews and reporting of progress towards meeting the targets set, with the full and meaningful involvement of civil society, in particular people living with HIV and key populations.

Accountability depends on full and meaningful participation. Yet, people living with HIV, key populations, civil society and human rights defenders face increased restrictions on their rights to engage in the public lives of their communities and countries. Without such engagement of these groups, full accountability will not be possible. While the search for accountability is at the heart of

¹¹ For data on communities in the HIV response, see UNAIDS www.unaids.org/sites/default/files/media_asset/UNAIDS_JC2725_CommunitiesDeliver_en.pdf

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what national, regional and international human rights systems do, it should preoccupy governments, the UN, and civil society. Accountability is a pillar upon which social justice and sustainable development are built. While accountability is a core principle of human rights-based responses, accountability principles and mechanisms can help to improve policymaking by identifying systemic problems in order to make service delivery systems more effective and responsive.