

UNAIDS

Preparing for
the Future



Report of the UNAIDS
Leadership Transition
Working Group



UNAIDS Leadership Transition Working Group

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This report was drafted by Ruth Levine, Ngaire Woods, Danielle Kuczynski and Devi Sridhar, with the input of working group members. Members of the working group participated in a personal capacity and on a voluntary basis. The report reflects a broad consensus among the members as individuals, though not all members necessarily agree with every word in the report. This text does not necessarily represent, and should not be portrayed as representing, the views of any single working group member, the organizations with which the working group members are affiliated, Oxford University, the Global Economic Governance Programme or its funders, the Center for Global Development, or the Center's funders and board of directors.

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Preface

When leaders change, so can institutions. At the Center for Global Development we have taken the opportunity of leadership change at major global institutions to ask questions about their mandates, resources, and governance and to propose (or not) changes and reforms. Our series has included the World Bank (June 2005), the InterAmerican Development Bank (January 2006), the African Development Bank (August 2006), and the Global Fund to Fight AIDS, Tuberculosis and Malaria (October 2006). Now, with the departure of Dr. Peter Piot as Executive Director of the Joint United Nations Programme on HIV/AIDS (UNAIDS), Ruth Levine, who leads our global health policy program, has collaborated with Ngaire Woods, Professor of International Political Economy and Director of University College for Oxford University's Global Economic Governance Programme, to lead a distinguished working group asking how that unique body should evolve to meet future needs.

In the course of this project the working group members found how deeply held the views about UNAIDS are and how expansive the hopes for its contributions in the future. Its defenders and challengers alike are passionate

and bring a diversity of perspectives—from those focused on protecting human rights to those engaged in the intricacies of UN reform, from epidemiologists concerned about the integrity of health data to civic activists who see the global response to HIV/AIDS as too slow and too limited. Given the breadth of stakeholders involved directly and indirectly in the work of UNAIDS, members tried hard to recognize a range of points of view, both from members of the working group as well as from participants at three consultations.

I am hopeful that the recommendations in this report help UNAIDS consolidate the successes of the past decade and focus squarely on areas in which it has unique and needed contributions to make in the future: giving voice to the voiceless, pushing for a more effective response within the UN system, building and disseminating evidence for better policies and programs, and bolstering the capacity for action at the country level. Those of us on the outside will be watching with interest.

Nancy Birdsall
President
Center for Global Development

Acknowledgments

Many individuals helped to shape this report. First, we would like to thank the members of the UNAIDS Leadership Transition Working Group, who gave their time, intellect, and patience over the months that it took to pull the report together. Their expertise and sharp observations brought clarity, humanity, and depth to the final recommendations. We thank them for their invaluable contributions.

The report draws on a series of interviews and global consultations (see annexes B and C for lists). We thank the interviewees we consulted throughout this project who provided unique insights into the workings of UNAIDS. We would also like to thank the participants in the three global consultations held in Washington, D.C., Oxford, and Durban. The participants at these meetings provided valuable and broad-reaching insights and ideas that spanned from Capitol Hill to the front lines of the pandemic in sub-Saharan Africa. We hope that the diverse views presented are reflected in this final product.

We also thank the team at the Center for Global Development for their contributions. Acknowledgment goes to Heather Haines for her assistance with the Washington consultation and Kristie Latulippe for her substantial efforts in planning the first consultation and for her intellectual contributions to the background

paper. We would also like to thank Nancy Bird-sall for her thoughtful comments on the report and Lawrence MacDonald, John Osterman, and the communications team for their ideas and ongoing support.

The success of the second consultation is owed to the team at the Global Economic Governance Programme, particularly Reija Fanous and Edward Joy. This meeting provided a great turning point for the project, helping to focus the discussion that emerged from the Washington consultation.

Particular thanks go to the team at the Health and Economics Research Division (HEARD) at the University of KwaZulu-Natal in Durban, South Africa, and Alan Whiteside for hosting our third consultation. This meeting reflected a valuable country-level perspective. Special thanks go to Andy Gibbs at HEARD—Andy's careful collaboration from the start of the project and work in pulling together the consultation were invaluable.

The content of this report significantly benefited from a review by Lindsay Knight, whose expertise with UNAIDS introduced extra precision and refinement.

Finally, we would like to thank Todd Summers for intellectual contributions and the Bill & Melinda Gates Foundation for the grant that facilitated this work.

Summary

Established in 1996, the Joint United Nations Programme on HIV/AIDS (UNAIDS) brings several United Nations agencies together around a joint mandate to lead, strengthen, and support an expanded and multisectoral response to the AIDS epidemic.

With many accomplishments to its credit, UNAIDS stands as a unique example of a cosponsored UN body. It has been a visible player over the past decade, as the AIDS epidemic has achieved global prominence as a political and social cause. Since its inception, UNAIDS has been led by its founding Executive Director, Dr. Peter Piot, with whom the program became closely identified. With his departure in December 2008 and the selection of Michel Sidibé as his successor comes an opportunity to reflect on both the strengths and shortcomings of UNAIDS. In the United States and elsewhere calls for expanded commitments to global health—with an Institute of Medicine committee recently recommending that the United States increase official development assistance for global health to \$15 billion over four years¹—and the proliferation of actors working on HIV and AIDS make this a particularly timely moment to question the role of UNAIDS in responding to the pandemic.

The UNAIDS Leadership Transition Working Group was convened in July 2008 by the Center for Global Development and Oxford University's Global Economic Governance Programme as an independent ad hoc panel with the mandate to formulate a set of recommendations for the next executive director and the governing Programme Coordinating Board of UNAIDS. Working group deliberations were

informed by academic research, interviews, and consultations in Washington, D.C., Oxford, and Durban.

Sparked by the question *do we need UNAIDS?*, the working group agreed that there are important reasons for UNAIDS to continue. First, the nature of HIV/AIDS—its relationship to issues of human rights and political marginalization and its profound and multisectoral determinants and consequences—calls for a response above and beyond many past responses to health conditions. Second, the commitments at national and global levels to support the response to HIV and AIDS must be fulfilled, and UNAIDS is uniquely positioned—as a special part of the United Nations—to ensure this. Third, given its engagement with both UN member states and civil society, UNAIDS can promote prevention, care, and treatment approaches based on both scientific evidence and respect for human rights.

While the rationale for UNAIDS is strong, working group members and many of those who contributed ideas and information to the working group process see significant room for strengthening the program. The working group believes that, to be most effective, the core mission of UNAIDS should be to use its status and strategic connections as a UN entity to press governments to uphold their existing commitments and to take on new ones that reflect approaches to containing and treating the AIDS epidemic that are grounded in

1. See Institute of Medicine 2009.

both scientific evidence and human rights. To achieve this mission, UNAIDS should focus on seven areas.

1. Track government commitments and drive a long-term, strategic agenda on HIV/AIDS that includes strengthening health systems and building national self-sufficiency

UNAIDS should continue to play a key role in holding both donor and other country governments accountable by tracking commitments that have been openly made and forging deeper commitments for a long-term response to the pandemic. To date, this has been an area of strength for UNAIDS. Still, UNAIDS should reinforce its ability to track funding levels and uses at the country level, using transparent dissemination of credible information as the main means of promoting fulfillment of commitments.

The working group suggests innovative areas of focus for the next phase of commitments to HIV/AIDS:

- Using the intensity and international visibility characterizing the recent nature of the response to AIDS to strengthen health systems in ways that have broad spillover benefits to other health problems.
- Promoting a sustained response that fosters greater country-level financial commitments to health.
- Fostering consensus and support for human rights-centered policies and approaches for effective HIV prevention and treatment, recognizing the needs of marginalized and criminalized populations.
- Developing benchmarks for the cost, quality, and effectiveness of key interventions.

2. Take a firm stand to promote policy guidance that is based on evidence and centered on human rights

UNAIDS has an important role to play as a clearinghouse for credible scientific evidence—defined broadly as social, behavioral, and biomedical data and analyses—about the magnitude, nature, and causes of the pandemic; the effectiveness of different

prevention, care, and treatment approaches; and the potential resource requirements, financial and otherwise. UNAIDS has been a leader in the field of HIV and human rights—for example, in 1996 and 2006 the UNAIDS Secretariat and the UN Office of the High Commissioner for Human Rights jointly published a seminal compendium, the International Guidelines on HIV/AIDS and Human Rights.² Still, it has recently been criticized for buckling under political pressure on some important issues. Maintaining its lead in this area will require vigilant insulation from the pressure of politics (on topics such as sex work and injecting drug use) and a willingness to underline to governments why they must work harder for marginalized at-risk groups, however politically difficult this may be. The working group stresses that the activities of UNAIDS must be guided by evidence rather than politicking.

3. Promote comprehensive care in prevention, treatment, and support, particularly in underpromoted intervention areas

In part due to political difficulties in scaling up, and in part due to a donor and advocacy focus on treatment objectives, prevention interventions have received less attention than treatment interventions. Although prevention and treatment are counterparts, prevention—particularly among populations with high rates of infection such as prisoners, injecting drug users, sex workers, and men who have sex with men—is an area where evidence-based policies and financial commitments have been sorely lacking and where UNAIDS can make a significant contribution.

4. Focus on creating more opportunities for marginalized voices in national policymaking

UNAIDS should continue to expand its work in supporting national responses through links to country governments, national AIDS councils (NACs), and local civil society, particularly

2. OHCHR/UNAIDS 2006.

groups of people living with HIV. UNAIDS has a special role to play in creating opportunities for marginalized and criminalized populations affected by HIV to actively participate in the design and monitoring of policies and the allocation of resources.

5. Reduce wasteful capacity-building efforts by brokering higher-quality, long-term, locally demanded technical support

UNAIDS builds capacity for national responses by linking governments, NACs, and civil society to financial resources and high-quality technical support. Governments need assistance with improving capacity for policy development, program design, and implementation. Key civil society groups, particularly those that represent marginalized populations, need assistance with coalition development, advocacy, budget tracking, and other activities, and they often need established organizations to recognize their legitimacy. UNAIDS has several mechanisms to do this, including the recently created Coordinated AIDS Technical Support database. However, the roles of existing support entities are unclear, and quality varies. UNAIDS should immediately address issues related to quality of technical assistance.

6. Enhance coordination within the UN family and with other donors, and use clear milestones to track progress

UNAIDS has contributed to coordination through initiatives like the “Three Ones” and to monitoring progress in expanding access to HIV treatment, but coordination remains a key challenge. UNAIDS should work with cosponsors to assess whether current mechanisms, such as the Committee of Cosponsoring Organizations, are serving their purposes. UNAIDS should carefully examine how it can align with the “One UN” reform. Milestones toward better coordination should be created and used to track progress.

7. Examine the structure, management, and operations of UNAIDS

The working group suggests that an in-depth organizational assessment occur with four aims by January 2010:

- Making the governing board more transparent and representative of those most affected.
- Improving the coordination framework for joint funding, priority setting, and implementation.
- Instituting robust mechanisms for independent, scientific, and technical review and oversight.
- Aligning the staffing in Geneva and within countries with the institutional mission.

About this report

In January 2009 Michel Sidibé assumed leadership of the Secretariat of the Joint United Nations Programme on HIV/AIDS (UNAIDS) from its founding Executive Director, Dr. Peter Piot. With this transition comes an opportunity—and an imperative—to re-examine the role of the organization so that UNAIDS can most effectively contribute to the global response to HIV and AIDS.

Launched in 1996, UNAIDS is a unique umbrella program that brings together 10 UN agencies around a joint mandate to lead, strengthen, and support an expanded response to the AIDS epidemic (see box 1).

UNAIDS has changed significantly since its inception. The Secretariat has grown in staff and budget—now with about 900 employees and more than 80 country offices. It has had an effect well beyond the UN system as an advocate for increased funding and attention to the AIDS epidemic. Interpreting its mandate broadly, it has undertaken a range of initiatives to generate and share information and to mobilize political and financial support.

During the past 12 years UNAIDS has also frequently been the object of criticism. Some have charged that UNAIDS has failed to stand up to conservative political pressures and in turn failed to protect the rights of marginalized populations, such as sex workers and men who have sex with men—people who are also criminalized in many countries. Many also criticize UNAIDS for not working effectively with civil society. And others have pointed out wide variations in the capacity of UNAIDS staff to provide high-quality technical support at the country level.

The world's understanding of HIV and AIDS and the responses within the broader dynamics of development policy have also changed dramatically. We know more today about what

drives epidemics of multiple etiologies,³ and we have seen the introduction of new, better, and more accessible interventions for prevention, treatment, and palliative care. Unprecedented financial resources have been mobilized for HIV and AIDS while international public and private organizations dealing with the epidemic have proliferated. And, as AIDS has grown in prominence on the international agenda and as a part of donor aid flows, the calls for taking a systemic approach, for “harmonizing,” for “delivering results,” and for fostering “country ownership,” also have grown louder throughout the domain of development assistance.

With the transition in leadership, the moment is opportune to ask whether and how UNAIDS should change to meet the dynamic needs of responding to the epidemic in the future. To answer this question, Ruth Levine at the Center for Global Development (CGD) and Ngaire Woods of Oxford University's Global Economic Governance Programme (GEG) convened the UNAIDS Leadership Transition Working Group.⁴ The working group includes 15 senior experts on global health and HIV and AIDS from the donor, academic, civil society, and official government communities (see

3. Whiteside 2008.

4. Support for this project was generously provided by the Bill & Melinda Gates Foundation as part of the HIV/AIDS Monitor Program of the Center for Global Development.

Mission: As the main advocate for global action on HIV and AIDS, UNAIDS leads, strengthens, and supports an expanded response aimed at preventing transmission of HIV, providing care and support, reducing the vulnerability of individuals and communities to HIV, and alleviating the epidemic's impact.

2008/09 Biannual budget: \$469 million.

Scope: More than 80 countries worldwide.

Leadership (as of January 2009): Michel Sidibé, Executive Director of the UNAIDS Secretariat, Under Secretary-General of the United Nations.

Program structure and organization: UNAIDS is a joint unified program of the United Nations. The program became operational on January 1, 1996, and started with six “cosponsors”—UN organizations that contribute efforts and resources to the AIDS response—(United Nations Children’s Organization, United Nations Development Programme, United Nations Population Fund, United Nations Educational, Scientific, and Cultural Organization, World Health Organization, and the World Bank). There are now four more: United Nations High Commissioner for Refugees, United Nations World Food Programme, United Nations Office on Drugs and Crimes, and International Labour Organization. Activities of the 10 cosponsors are laid out in the Joint Programme around seven principal outcomes.

Principal outcomes: These outcomes reflect the anticipated impact of activities across the cosponsors through the Joint Programme in the 2008–09 biennium:

- Leadership and resource mobilization.
- Planning, financing, technical assistance, and coordination.
- Strengthened evidence base and accountability.
- Human resources and systems capacities.
- Human rights, gender, stigma, and discrimination.
- Most-at-risk populations.
- Women and girls, young people, children, and populations of humanitarian concern.

Unlike the cosponsoring agencies, each with a specific mandate, the cosponsored program does not itself have a mandate but is intended to coordinate the work of the United Nations on the AIDS epidemic and to reach beyond the organization to all sectors of global society to forge a global agenda on HIV and AIDS. UNAIDS does not play a direct role in disbursing funds.

The program is served by a Secretariat based in Geneva, with more than 80 regional and country offices; it has a staff of more than 900 people in Geneva and in regions and countries.

Governance: UNECOSOC (Economic and Social Council of the United Nations) has formal governance responsibility over UNAIDS. Within the Joint Programme governance occurs through the Programme Coordinating Board (PCB) with membership from 22 country governments, the cosponsoring organizations, and civil society. The PCB reviews activities and programs of the Executive Director, as well as the UNAIDS Secretariat and the cosponsors.

There is also a Committee of Cosponsoring Organizations (CCO) comprised of the executive head or designated representative of each cosponsoring organization. The CCO meets twice a year to consider matters concerning UNAIDS and to provide inputs into the policies and strategies of UNAIDS.

The UNECOSOC resolution 1994/24, which defined the program, explains, “The Cosponsors will share responsibility for the development of the programme, contribute equally to its strategic direction, and receive from it policy and technical guidance relating to the implementation of their HIV/AIDS activities. In this way, the program will also serve to harmonize the HIV/AIDS activities of the Cosponsors.”¹

Note

1. This report mainly focuses on the work of the Secretariat, not the specific activities of each cosponsor on HIV and AIDS. The term *UNAIDS* is used throughout, as is common usage to mean the Secretariat (including country and regional offices) and sometimes the Joint Programme.

Source: See UNAIDS 2002a, b; 2008a; UNECOSOC 1994.

working group member bios in annex A). Members generously served as individuals and in a volunteer capacity.

The working group approach is based on earlier experiences. CGD formed working groups in the past to develop recommendations during leadership transitions at the Global Fund to Fight AIDS, Tuberculosis and Malaria and at major development banks, including the World Bank and regional development banks.⁵ In 2008 the Global Economic Governance Programme convened a group of developing

country health ministers and senior officials to discuss priorities and challenges in global health governance.⁶ In this tradition the UNAIDS Leadership Transition Working Group was convened to offer strategic recommendations for the new Executive Director of the Secretariat—who was appointed during this document’s production—and its Board. Thus, this report, while independent, unofficial, and unsolicited, has a particular audience.

5. CGD 2005, 2006a, b.

6. Global Economic Governance Programme 2008. See www.globaleconomicgovernance.org/wp-content/uploads/Working%20Group%20Report%20May%202008.pdf.

Working group discussions were supported by background work: approximately 50 semi-structured interviews targeting knowledgeable individuals (see annex B for the list of interviewees), a comprehensive academic and media review (see reference list), and consultation in Washington, D.C., Oxford, and Durban. Each of these consultations sought input from informed individuals about the comparative advantage of UNAIDS and the features required to fulfill core functions (see annex C for summary of consultations and annex D for a description of the methodology).

This report presents a synthesis of what was learned. It reflects the judgments of working group members, the consultation discussions, perceptions of knowledgeable individuals, and background research. It does not, however, attempt to comprehensively evaluate the work of the UNAIDS Secretariat or the cosponsors' work on AIDS. Given the nature of this exercise,

the findings and recommendations are based on a combination of available factual information and independent views. We recognize that in some cases progress in particular areas depends on more in-depth analysis, and we propose next steps toward that end.

This report touches briefly on the evolution of UNAIDS and presents key challenges for Mr. Sidibé and UNAIDS senior management. These are followed by a set of recommendations agreed on by working group members and targeted at the UNAIDS Secretariat and the Programme Coordinating Board of UNAIDS. The recommendations are not radical ones, and in some cases they reinforce initiatives already under way in UNAIDS. But in the context of a multistakeholder UN organization that is part of the larger UN governance system, serious and effective leadership will be needed to fulfill the recommendations while shaping organizational culture and engaging key constituencies.

Evolution of the AIDS epidemic and UNAIDS

In June 1981 the *Weekly Morbidity and Mortality Report* of the Centers for Disease Control and Prevention (CDC) described what would be recognized as the first reported cases of HIV in the United States, some rare pneumonias seen in five gay men.⁷ Doctors in Belgium and Paris had been seeing similar conditions in patients since the mid-1970s, mainly in Africans from the equatorial region or Europeans who had visited this area.⁸ Doctors in several African countries were also treating patients with similar symptoms; by 1983, AIDS cases had been identified in Congo, Rwanda, Tanzania, Zaire, and Zambia.⁹ Signs of a global epidemic were emerging, but for some years in both developed and developing countries funding for activities to prevent HIV transmission and to care for people living with HIV were not major priorities—mainly because many such people came from marginalized and stigmatized groups such as injecting drug users and men who have sex with men. Some politicians denied the existence of local epidemics; others insisted on compulsory HIV testing for people entering their countries and refused entry to those who were HIV positive.¹⁰

In the West gay rights activists mobilized for action on prevention, both within their own community and the domain of public policy.¹¹ The development of Highly Active Antiretroviral Therapy (HAART)¹² in 1996 brought a highly sought clinical advance; antiretroviral drugs could significantly delay the onset of AIDS, though at that time many people in the developed world could not afford them, let alone the many thousands in need in developing countries. The arrival of these drugs, to some extent, turned people toward overcoming

financial and other barriers to obtain quality treatment, rather than toward prevention.

As the epidemic exploded in many countries, particularly in sub-Saharan Africa, most governments were slow to explicitly recognize the magnitude and nature of the problem. When they did, it often emerged from personal reasons. In 1989, President Kaunda of Kenya, for example, was one of the first African leaders to speak out about the need to fight the AIDS epidemic after losing his son to AIDS. Only as governments in rich and poor countries alike began to recognize and come to grips with the scope and impact of the global epidemic—including threats the disease posed to economic and social development progress in high-prevalence countries—did AIDS move higher up the policy agenda.

Since then, the institutional capacity to respond to this complex disease has expanded, with growing numbers of organizations working

7. CDC 1981; Behrman 2004, 5.

8. Iliffe 2007.

9. Knight 2008.

10. Knight 2008; Caldwell 1994.

11. Piot, Russell, and Larson 2007.

12. National Institutes of Health 1998.

on HIV and AIDS. The epidemiological understanding of this disease has also deepened, and epidemics of multiple etiologies have been characterized.¹³ While progress is still needed, people living with HIV/AIDS are gaining voice in policy discourse and playing a major role in mobilization, advocacy, implementation, and governance.

Biomedical science, which made effective AIDS treatment a reality, continues to play an important role, though it is now clear that hoped-for breakthroughs such as vaccines and microbicides are unlikely to be available for many years.¹⁴

The United Nations response to the AIDS epidemic has also evolved in important ways since leaders first started to recognize the global magnitude and nature of the problem and to understand the importance of an all-out effort to mitigate its potential impact. Initially defined as an emerging health threat, the epidemic was placed under the purview of the World Health Organization (WHO). In 1986 the WHO established the Control Programme on AIDS (CPA) under the leadership of Dr. Jonathan Mann, a leading expert on AIDS. In 1987 the CPA was re-named the Special Programme on AIDS (SPA). Slightly more than a year later, in January 1988, the SPA became the Global Programme on AIDS (GPA)—in recognition of the fact that the epidemic was neither temporary nor short term.¹⁵ Support from international donors was slow to come and modest. At the outset GPA had few staff and a budget of about \$5 million, funded with donor contributions raised through Mann's personal outreach.

Early on, the global response to AIDS was met by many with discrimination and fear, but Mann felt otherwise: "If we do not protect the human rights of those who are infected, we will endanger the success of our efforts, national and international, to control AIDS."¹⁶ Mann's emphasis on human rights set the target early on

for the United Nations' work on the epidemic, even if it often failed to meet it. With the publication of the landmark "Global Strategy for the Prevention and Control of AIDS"¹⁷ and with eventual support from WHO Director-General Dr. Halfdan Mahler and early contributions from the United States and many European countries, between 1987 and 1989 the budget had reached \$90 million, and GPA staff numbered near 400.¹⁸

In 1990, when Mann resigned in the face of tension with WHO's Director-General Dr. Hiroshi Nakajima, WHO's response to the epidemic was in peril. At the time, a WHO staff member said: "It's not a question of how well the program will do after Jon Mann, but whether there will be a program worth talking about."¹⁹

Dr. Michael Merson became head of GPA in 1990, amid growing concern from the engaged donor community about the ability of WHO to manage the program and the now-apparent need—in light of the relationship between the epidemic and a range of sectors other than health—to coordinate related activities across UN agencies. An external review of GPA led to the decision to replace the program with a new body that would coordinate the work of the United Nations on AIDS. The external review concluded that "no single agency is capable of responding to the totality of the problems posed by AIDS; and as never before, a cooperative effort, which is broadly based but guided by a shared sense of purpose, is essential."²⁰ In 1994 it was agreed that a joint and cosponsored program would be established. The original six cosponsors were the United Nations Children's Fund (UNICEF), United Nations Development Programme (UNDP), United Nations Population Fund (UNFPA), United Nations Educational, Scientific, and Cultural Organization (UNESCO), and the World Bank—because at the time they were members of the

13. Whiteside 2008.

14. See www.iavi.org and www.mtnstopshiv.org for more information.

15. Knight 2008.

16. WHO–GPA 1992.

17. WHO World Health Assembly 1987; Mann 1987.

18. Behrman 2004.

19. Hilts 1990.

20. GPA Management Committee 1992.

GPA Management Committee. Although the full story of the origins of UNAIDS is a complicated one, and different participants and observers emphasize distinct aspects of the program's creation, several reasons have been cited for the establishment of the Joint Programme:²¹

- Dissatisfaction among donors with the overall WHO management—encompassing, in part, criticism that WHO could not coordinate rival UN agencies.
- An interest by Organization for Economic Cooperation and Development (OECD) donors in having more direct control over multilateral aid mechanisms, as well as the recognition that due to the multisectoral nature of AIDS, agencies with sector-specific mandates or those directly responsive to individual governments of member states were poorly positioned to respond.
- An impetus toward UN reform, with UNAIDS seen as an opportunity to demonstrate the potential of the UN as a whole with a joint work plan, funding responsibilities, and shared budget among the cosponsoring agencies.
- A growing understanding in the epidemic response, driven in part by effective advocacy of civil society organizations, that because of the nature and etiology of the disease, responses to HIV and AIDS require dealing with sex—heterosexual and homosexual—with use of illicit drugs, and with all the social, cultural, and legal ramifications they carry. Concentrated attention to issues of marginalization, violation of human rights, and criminalization of the most affected populations is part of this challenge. It was felt that UNAIDS as an entity independent of cosponsor mandates would have more latitude than WHO to work across sectors and to talk candidly about the many sensitive issues related to guiding a range of rights-based programs.

But from the complicated and painful birth of UNAIDS it is important to note that the push for the new program came from the donors (supported by AIDS activists) and that from the start there were varying degrees of

opposition from some of the UN agencies that eventually became cosponsors of UNAIDS. This was fueled by a lack of clarity about the role of the Secretariat relative to that of the cosponsors. Opposition continued and made the lives of UNAIDS Secretariat staff very difficult at times, including at the country level. Even to this day, wrangling over culturally sensitive areas, such as services for sex workers and men who have sex with men, in the fine details of policy documents is not unusual at meetings of Secretariat staff and cosponsors.

Under the UNECOSOC resolution 1994/24, the primary objective of establishing UNAIDS was to lead an expanded, multisectoral, broad-based response to the AIDS epidemic.²² The focus of the organization was to

achieve and promote global consensus on policy and programmatic approaches; strengthen the capacity of the United Nations system to monitor trends and lessons learned and to ensure that appropriate and effective policies and strategies are put into operation at country-level; strengthen the capacity of governments to draw up comprehensive national strategies, and to coordinate and implement effective HIV/AIDS activities at country level; promote broad-based political and social mobilization to prevent and control HIV/AIDS within countries, ensuring that national responses involve a wide range of sectors and institutions; and advocate greater political commitment in responding to HIV/AIDS epidemics at global and country levels, including the mobilization and allocation of adequate resources for HIV/AIDS-related activities.²³

The first UNAIDS Executive Director, Dr. Peter Piot, was appointed in 1995. Since then, the UNAIDS Secretariat has grown: its annual budget is now \$469 million, and staff have

21. UNAIDS 2002a.

22. UNECOSOC 1994.

23. World Health Assembly Executive Board 93rd Session 1993.

increased to some 289 workers at the Secretariat's Geneva headquarters and by an additional 611 in regional and country offices (see box 1 for current overview of UNAIDS).

Since its creation, UNAIDS has played a major part in influencing the global response to HIV. It has focused on raising the visibility of the epidemic, in particular by advocating greater funding, political commitment, and leadership. In an increasingly crowded field of global health actors the Secretariat has attempted to help cosponsors improve their HIV efforts (such as with the World Bank's Multi-country AIDS Programs in Africa and the Caribbean);²⁴ aimed to collaborate beyond the UN family (such as with the Global Fund to

Fight AIDS, Tuberculosis and Malaria); sought to widen the reach of indigenous efforts (such as with The AIDS Support Organization in Uganda, now the largest provider of HIV and AIDS services in Africa);²⁵ and engaged with new partners (such as with key private sector programs like that of Merck's African Comprehensive HIV/AIDS Program).²⁶ Several of these actors have greater financial clout than the Secretariat—but UNAIDS has not become obsolete. As a UN organization, it still has a unique legitimacy and role in the response to HIV and AIDS.

In a changed landscape, what should the future role be for UNAIDS?

24. Görgens-Albino et al. 2007.

25. For more on TASO, see <http://www.tasouganda.org/>.

26. Business Action for Africa 2006.

Continuing an exceptional response: Key roles for UNAIDS

In considering the future of UNAIDS, some challenges deserve mention:

- The AIDS epidemic has received the largest international, institutional, and financial response of any health condition relative to its contribution to the global burden of disease.²⁷ In large measure, the relatively successful mobilization of resources to date has resulted from advocacy that has framed the disease as exceptional—especially when compared with other infectious and chronic health problems: it kills adults in the prime of their lives, it is spread by sex and illicit drugs, it affects those who are largely marginalized and often criminalized, and it is hyperendemic in Southern Africa, where so many are affected by poverty and countries are burdened by weak health systems. Despite these factors, whether the disease should in fact be seen as exceptional has been contested by some commentators,²⁸ bringing to question whether it warrants a stand-alone UN organization with a single-disease focus.
- Increasingly, global and country-level policy-makers are calling for recognition of synergies and complementarities between services for HIV and other health conditions competing for attention and resources. Slower than expected progress toward other health priorities, including child and maternal health goals, has fueled debates about whether funding for HIV is crowding them out.²⁹ In program implementation there is relatively little evidence on whether or how attention to HIV positively or negatively affects the delivery of or demand for other health services.³⁰ Thus, linking efforts to treat and prevent HIV to efforts to strengthen health systems more broadly, as well as to food and nutrition policies and to investments in education and development, will continue to be crucial—and will continue to form part of the agenda that UNAIDS must tackle.³¹
- In the future other topics may overtake health and the AIDS epidemic for funding and attention. Although development assistance for health increased from 4.6% of official development assistance (ODA) in 1990 to close to 13% in 2005 and such institutions as the World Bank, the Global Fund, Global Alliance for Vaccines and Immunization (GAVI), and many other health-oriented institutions have brought unprecedented attention to health as a part of the development agenda, other priorities such as climate change are gaining ground.³² While new monies are justified in a number of areas, and a credible case can be made that all development sectors merit large increases in aid flows, there also are fears that the global financial and economic crisis will lead to less assistance from traditional donor nations. Heads of state in the United States, United Kingdom, and other countries have recently reaffirmed their commitment to increase funding for global health and HIV

27. Sridhar and Batniji 2008.

28. Cheng 2008; England 2008.

29. Shiffman 2007; Morris, Cogill, and Uauy 2008.

30. Oomman, Bernstein, and Rosensweig 2008; WHO 2008.

31. Loevinsohn and Gillespie 2003; Sperling 2009.

32. World Bank 2007. For example, in May 2008 the World Bank launched its Strategic Framework for Development and Climate Change.

and AIDS programs.³³ Still, worries persist that spending may contract. UNAIDS promotion of a sustained, adequately financed response remains needed.

- In the rapidly expanding field of global health the mechanisms for delivering development assistance are fragmented and overlapping. While UNAIDS has contributed to coordination efforts through the “Three Ones” and Universal Access consultations,³⁴ many actors outside the direct purview of UNAIDS play prominent and novel roles in fundraising, policy advice, and program development. To name only a few: the U.S. President’s Emergency Plan for AIDS Relief (PEPFAR), the Global Fund, UNITAID, and the Clinton HIV/AIDS Initiative (CHAI). New initiatives rooted in the principles of the 2005 Paris and 2008 Accra Declarations on aid effectiveness³⁵ have been developed to address coordination problems, at least in selected countries. Examples include the One UN reform initiative, which seeks to harmonize programs among UN actors at the country level, and the International Health Partnership+ (IHP+), which brings together leading donors and mobilizes additional funding within compacts with selected countries around a

33. Wintour 2008; U.S. President George W. Bush, October 21, 2008, speech at the White House Summit on International Development.

34. The “Three Ones” are one AIDS action framework, one national AIDS coordinating authority, and one agreed country-level monitoring and evaluation system. For more information on Three Ones see www.unaids.org/en/CountryResponses/MakingTheMoneyWork/ThreeOnes. For more information on Universal Access see www.unaids.org/en/PolicyAndPractice/TowardsUniversalAccess/default.asp.

35. The 2005 Paris Declaration (www.oecd.org/document/18/0,2340,en_2649_3236398_35401554_1_1_1_1,00.html) builds on the following declarations and commitments: Rome 2003 (see www.aidharmonization.org/ah-wh/secondary-pages/why-RomeDeclaration), Marrakech 2004 (see www.mfdr.org/1About.html), and links to Monterrey 2002 (see www.un.org/esa/ffd/monterrey/MonterreyConsensus.pdf). It is focused on harmonization and alignment for managing aid. The Accra Agenda for Action 2008 further affirms these principles (see siteresources.worldbank.org/ACCRAEXT/Resources/4700790-1217425866038/ACCRA_4_SEPTEMBER_FINAL_16h00.pdf).

national health plan.³⁶ For UNAIDS this means that coordination of UN agencies is happening in the midst of an increasingly complex environment, in which even the identity of an organization with a mandate for coordination is subject to dispute.

The UNAIDS Leadership Transition Working Group deliberations started by reflecting on whether UNAIDS is still needed, and if so, whether its objectives and structure require important modifications. The working group concluded that UNAIDS does have a unique and crucial role to play and that terminating or phasing out UNAIDS would send a devastating signal about the commitment and attention span of the international community. Working group members articulated three reasons why UNAIDS is still needed.

First, the AIDS epidemic is exceptional in the magnitude of its impact on development in many countries, especially because of its effect on working adults; its association with politically sensitive topics (sex and drugs) and stigmatized groups (sex workers, injecting drug users, and others); and its ambitious response (universal access to state-of-the-art treatment and prevention interventions). Addressing HIV and AIDS is not confined to the health sector.

Second, at a time when a long-term, sustained commitment is required, UNAIDS is needed to keep HIV and AIDS on the global development agenda and to support countries and civil society by emphasizing existing national and international commitments and forging new ones.

Third, UNAIDS has a key role to play in providing policy guidance on such imperatives as effective HIV prevention and universal access to treatment. Among the many actors working on HIV and AIDS, only UNAIDS has the backing of all UN member states to provide global leadership on AIDS, which now more than ever includes the challenging task of building consensus around the human rights-centered approaches that are vital to making headway on HIV prevention and treatment.³⁷

36. See UNDP 2007; IHP+ 2008.

37. Mann 1995; Open Society Institute 2007.

Nonetheless, changes are warranted. UNAIDS needs to refine and reshape its mission and identity in substantial and fundamental ways, to address new challenges. The first five-year review of the organization in 2002 alluded to confusion over what UNAIDS was meant to be: a sum of all UN activities on HIV/AIDS or of the parts of its cosponsors? Or a Geneva-based Secretariat with regional and country outposts, all under the loose rubric of multisectoralism and an expanded response?³⁸ To some extent, clarity is still lacking, and as mentioned, issues exist that divide or cause friction between cosponsors and the Secretariat.

Background interviews voiced a clear perception that UNAIDS is overstretched—serving

38. UNAIDS 2002a.

as a one-stop shop for policy, programmatic assistance, and epidemic tracking. Many see the UNAIDS Secretariat as oversized and opaque and in need of clear priorities that define a distinct niche among other organizations working on HIV. Clarity on some of these points may emerge from the second five-year evaluation of UNAIDS, which will be available at the end of 2009. However, following this important leadership transition, the working group offers a set of recommendations to Mr. Sidibé for the UNAIDS Secretariat and its regional and country outposts.³⁹

39. From this point forward, the term UNAIDS will refer to the Secretariat and its regional and country outposts, not to the activities of cosponsors, except where explicit distinctions are made.

Recommendations for the Secretariat's Executive Director and the Board

Fundamentally, the working group recommends that Mr. Sidibé and the Board refine the mission and mandate of UNAIDS. The UNAIDS Secretariat has become many things to many constituencies, and the incoming leadership should seize the opportunity to make a clear statement about the primary roles that the UNAIDS Secretariat can and should play. The UNAIDS Secretariat's unique "inside-outside" status—part of the UN system but outside any single agency—means it has the potential to function effectively as the engine of the Joint Programme and the wider global response. In turn, the working group believes that the core mission of UNAIDS should be to use its status and strategic connections as a UN entity to press governments to uphold their existing commitments and to take on new ones that reflect approaches to containing and treating the AIDS epidemic that are grounded in both scientific evidence and human rights. Toward this end, UNAIDS should engage in respectful collaboration and capacity building with those most affected by HIV/AIDS and drive a coordinated, long-term response informed by government and civil society perspectives.

1. Track government commitments and drive a long-term, strategic agenda on HIV/AIDS that includes strengthening health systems and building national self-sufficiency

UNAIDS can never be an enforcement agency. But it does and should continue to hold both donor and other governments accountable by tracking commitments that have been made openly. UNAIDS also needs to forge deeper commitments for a long-term response to the pandemic, particularly given global commitments made at the United Nations General Assembly Special Session (UNGASS) and reports to the UN General Assembly that countries are asked to make on an annual basis.⁴⁰ UNAIDS has been doing relatively well at this; but it needs to do more and do better—in

particular, at tracking funding levels and uses at the country level.⁴¹

In setting commitments UNAIDS could be innovative and bold in four ways: first, in looking at how to extend the commitment agenda to intensify responses to HIV/AIDS and to bring a results focus to other health areas and broader health systems strengthening; second, in promoting a sustained response that fosters greater country-level financial commitments to health, without letting donors off the hook; third, in driving consensus and support for the human rights-centered policies and approaches that are vital to effective HIV prevention and treatment

40. United Nations 2008.

41. For more information see www.ua2010.org/en/UNGASS/UNGASS-2008; for joint statement on transparency to UNAIDS see www.ua2010.org/en/UA2010/Universal-Access/Civil-Society-Papers/Shadow-Reports-2006/Transparency-Joint-Statement-UNAIDS.

and that recognize the needs of marginalized and often criminalized populations; and fourth, in developing benchmarking for the cost, quality, and effectiveness of key interventions.

Sustained political will and strong leadership are crucial to increase funding and reduce the number of new infections.⁴² Although some civil society organizations and academics “name and shame,” currently no official organization holds others to account or serves as a clearinghouse for information that permits interested parties to track commitments. This is a difficult task, especially for an organization funded by those that it needs to hold to account, but it is a role that a UN organization, with authority jointly conferred by UN member states, is uniquely placed to play.

The working group suggests that to better drive the commitment agenda in the ways suggested, UNAIDS should employ the following strategies:

- Publicly record and monitor global and national commitments and declarations, to encourage transparency and accountability. To do so, UNAIDS can establish a clearinghouse for information on HIV-related policy commitments by donor organizations and UN member states. This would include, for example, government policy commitments on access to prevention, treatment, and other services, including for marginalized people such as sex workers and refugees, as well as government policy on discrimination on the basis of sexual orientation or against criminals and HIV-positive migrants. Simply making available such information creates the conditions for the establishment of international benchmarks and standards and makes it possible for other actors to keep up pressure on politicians.
- Develop and disseminate information in a fully transparent form about what commitments—financial and otherwise—should be made by all relevant stakeholders to accelerate progress in fighting the epidemic. This means looking at what commitments have been made, which commitments have been fulfilled, and what is at risk of being

renewed on—such as for universal access and for financial commitments at the global level (the Gleneagles G-8 meeting) and among and within affected countries (the Abuja Declaration).⁴³ It also means taking a long-term perspective complementary to initiatives like aids2031,⁴⁴ by helping to set a commitment agenda that promotes national self-sufficiency and projects future responsibilities of donors and recipient governments.

- Generate credible projections as a tool to set commitments for future resource needs for health system strengthening and scaling up prevention, sustaining and expanding care and treatment, and driving a long-term response to HIV and AIDS predicated on human rights. For instance, the life-saving provision of antiretrovirals (ARVs) has established a long-term imperative for recipients that must be fulfilled.⁴⁵ UNAIDS could transparently project those implicit commitments based on state-of-the-art knowledge about life expectancy, costs of second-line drugs, and costs of effective delivery and meanwhile estimate the resources required for greatly enhanced prevention strategies.

It is important that UNAIDS recognize and disseminate information on the synergies that scaling up and maintaining resource flows for HIV and AIDS can, and should, have for other disease areas and health system strengthening, which ultimately contribute to national self-sufficiency. This is essential to develop projections that show the full costs of the pandemic beyond those of interventions such as training health workers, higher remuneration, and improved working conditions.

2. Take a firm stand to promote policy guidance that is based on evidence and centered on human rights

UNAIDS has an important role to play as a credible scientific clearinghouse for HIV/AIDS, with

42. Piot, Russell, and Larson 2007.

43. Kaisernetwork.org 2007; Govender, McIntyre, and Loewenson 2008.

44. For more information see www.aids2031.org.

45. Over 2008.

science defined broadly to include social, behavioral, and biomedical fields. Although UNAIDS has developed a large number of policy papers, position documents, and advocacy tools and provided much epidemiological information, the organization has been criticized for failing at times to fully ground its advocacy in the best available evidence and for lacking the courage to take a stand on hard issues.⁴⁶ UNAIDS should not shirk from sharing unpopular information with the policy community about the behaviors that contribute to the spread of the disease, the magnitude of resources required, the need to work respectfully with groups that face social disdain, and the chances for success or failure of various public health strategies.

In its early years of operation UNAIDS successfully integrated human rights and public health imperatives, as well as on-the-ground evidence of what works best, in framing policies and guidance on HIV prevention.⁴⁷ For example, unique guidelines were produced for legislators and parliamentarians on protecting the rights of disenfranchised populations vulnerable to HIV and on best practice programs for educating sex workers and their clients on prevention.

But in more recent years some critics have noted cases where UNAIDS abandoned evidence to appear more politically neutral. For example, UNAIDS was criticized for deemphasizing empowerment and overemphasizing alternative livelihoods for sex workers in a 2007 guidance note, a position inconsistent with previous UN statements on the rights of sex workers.⁴⁸ In one example UNAIDS was asked by key stakeholders to drop references in their policies to needle exchange programs, despite the necessity of such programs in preventing HIV wherever injection drug use is prevalent.⁴⁹ UNAIDS has also been criticized for failing to emphasize the practice of having concurrent sexual partners as a driver of the epidemic in Africa.⁵⁰ Although

not alone in its approach, UNAIDS has not adequately prioritized matching the response to a country's epidemic (that is, whether it is concentrated in specific groups such as injecting drug users or dispersed throughout the general population) as key to effective prevention.

The recent report of the independent Commission on AIDS in Asia takes the first step away from political influence of the kind that can dilute the evidence base of policy and program actions. The Commission, convened by, though independent of, UNAIDS, recognized that many epidemics in Asia are driven by sex work, injecting drug use, and sex between men, and the Commission has urged UNAIDS and national governments to find ways of working respectfully with sex workers, their clients, men who have sex with men, and people who inject drugs to ensure that their experiences inform program solutions, however politically difficult this may be.⁵¹ The Commission's report illustrates the range of evidence- and rights-based policy and programmatic guidance that UNAIDS—the Secretariat and the cosponsors—should be providing. It calls for wide-ranging prevention, treatment, and care services for all who are living with and vulnerable to HIV, including the marginalized groups that are most affected. At the same time, the Commission points to the fact that, though casual sex among young people remains a minor factor in Asia's HIV epidemics, significant resources for prevention have been aimed at this group, instead of those most at risk.

3. Promote comprehensive care in prevention, treatment, and support, particularly in underpromoted intervention areas

Prevention and treatment of HIV are essential in reducing infection rates and deaths, but until fairly recently, insufficient resources were spent on prevention,⁵² and in many places prevention interventions have not been as well supported as have treatment interventions. A

46. Gordon 2008; Epstein 2007.

47. Dube and Csete 2008.

48. Canadian HIV/AIDS Legal Network 2007.

49. *The New York Times* 2005.

50. Epstein 2007.

51. Commission on AIDS in Asia 2008; Dube and Csete 2008.

52. Global HIV Prevention Working Group 2007.

recent *Lancet* editorial decried, “The absolute amount of preventive practice and science has simply been too little. The mix of interventions has been wrong. Leadership and management of programs to deliver these interventions have been weak. It is fair to say that, despite greatly increased resources, the state of the response to AIDS is currently at a vulnerable moment.”⁵³ While groups that are left out of prevention are often also left out of treatment, programs like PEPFAR have established a treatment imperative that has had a further debilitating effect by drawing attention away from prevention interventions, despite their narrowly focused investments in prevention.⁵⁴ Globally, HIV prevention services reach fewer than 1 in 5 sex workers and fewer than 1 in 10 injection drug users and men who have sex with men.⁵⁵ This represents an international failure to mitigate the inexorable growth in the number of cases and the consequent burden on individuals, households, communities, and governments.

Prevention, particularly in relation to populations with high rates of infection, such as prisoners, sex workers, injecting drug users, and men who have sex with men, is an area in which evidence-based policies are sorely lacking. UNAIDS has an important contribution to make in driving a prevention agenda that avoids harmful polarization against treatment. Populations excluded from prevention are also systematically excluded from antiretroviral therapy in many countries, to the detriment of effectiveness of national responses. UNAIDS should also do more to push for removal of these barriers to treatment and to support all forms of care, including palliative care where needed.

4. Focus on creating more opportunities for marginalized voices in national policymaking

By building close relationships to member country governments, national AIDS councils (NACs), Country Coordinating Mechanisms

(CCMs), and local civil society groups, UNAIDS can help involve all people living with and vulnerable to HIV, including marginalized groups, in country responses to the epidemic. During consultations this was returned to as a fundamental need and an area to which UNAIDS should continue to commit itself—but with more intensity and focus than in the past.

The role of civil society can be unique and complementary to government, particularly in work on HIV and AIDS where politicians can be pressured into responding to the needs of populations that might otherwise be invisible. Civil society groups can be effective in holding governments accountable for national and global commitments. And civil society plays a critical role in working for increased expressions of demand for quality services to national governments and bilateral and multilateral donors such as the Global Fund. Such African organizations as Uganda’s The AIDS Support Organization (TASO) and South Africa’s Treatment Action Campaign (TAC) use community-based action and legal tactics to motivate appropriate government responses.⁵⁶ Indigenous grassroots civil society with leadership that includes people living with HIV and people from marginalized populations is needed to:

- Ensure high-quality, equitable treatment and prevention programs.
- Create strong accountability systems.
- Strengthen political will at the country level to fight AIDS and increase investments in health.
- Increase the quality of interactions with national and global funders.
- Move faster to reach the targets countries have already committed to.

And UNAIDS should play a stronger role in supporting and calling for such civil society leadership and in helping strengthen those organizations to serve more effectively.

UNAIDS should help build grassroots capacity to advocate and increase UNAIDS linkages to other organizations and political venues. For instance, some working group members

53. Horton and Das 2008, 421.

54. Over 2008.

55. Dube and Csete 2008.

56. Piot, Russell, and Larson 2007.

noted that UNAIDS needs to expand its work with faith-based organizations. Capacity building would mean working effectively with all affected people—which means in many countries especially with organizations for sex workers, injecting drug users, men who have sex with men, and other marginalized populations (such as adolescent girls, migrants, and refugees)—to gain voice and address the structural, legal, and societal barriers that may face them. UNAIDS has helped build capacity in the past, for example, in Malawi where it assisted in mobilizing an early grassroots response.⁵⁷

5. Reduce wasteful capacity-building efforts by brokering higher-quality, long-term locally demanded technical support

UNAIDS has responded to the gaps in country-level planning, program design, and implementation capacity by linking governments, NACs, and civil society to financial resources and technical support, including for the preparation of proposals for submission to the Global Fund and other funding sources. Governments need help to improve capacity for policy development, program design, and implementation; key civil society groups, particularly those that represent marginalized populations, need support with coalition development, advocacy, budget tracking, and other activities and may need an established body to recognize their legitimacy. At times UNAIDS has demonstrated that it can play an important role in supporting governments and regional bodies through capacity-building activities such as with the Southern African Development Community, with which UNAIDS assists in the development of regional research agendas and epidemic update reports.

The working group believes that UNAIDS should continue to focus on supporting country-level capacity, and in doing so, it should strive for uniformly high-quality technical support, restricting its role to “matchmaker” or broker. Anecdotes offered by individuals throughout consultations highlighted instances of where

57. Knight 2008.

the role of UNAIDS as a broker and implementer of technical assistance became confused. In addition, there were reports of variable quality in some of the Technical Support Facilities (TSFs)—the pools of consultants managed through UNAIDS—and in some cases a lack of knowledge of the roles of other entities, such as the Global Implementation Support Team (GIST) and the AIDS Strategy and Action Plan Service (ASAP),⁵⁸ two additional technical assistance facilities. The new Coordinating AIDS Technical Support database (CoATS), established in October 2008, aims to provide timely information on the type, quality, and origin of expertise delivered in country. The impact of this initiative has yet to be assessed.⁵⁹

UNAIDS should ensure that support is making a positive impact. To do so, the Secretariat should foster feedback mechanisms that are transparent and clearly communicate to end users how technical support entities complement each other. In delivering or brokering technical support, UNAIDS should ensure that the support is sustainable and available over the long term. To the maximum extent possible, technical support should come from local sources. To reduce unfair competition and help build local capacity, only where local support is not available should UNAIDS turn to resources outside the given country or region.

6. Enhance coordination within the UN family and with other donors, and use clear milestones to track progress

Although UNAIDS has contributed to coordination through such initiatives as the “Three Ones” and to monitoring the progress in expanding access to treatment, it can do more and

58. UNAIDS 2008c. For more on technical assistance see www.unaids.org/en/CountryResponses/TechnicalSupport/default.asp.

59. CoATS is a shared database with up-to-date information on technical support activities. It is anticipated that major partners will input data on planned and ongoing technical support activities. The database will provide information on providers, funders, and recipients of such support. For more information see www.unaids.org/en/KnowledgeCentre/Resources/FeatureStories/archive/2008/20080310_CoATS.asp.

better to coordinate the programs of cosponsors and to collaborate with other actors.

At present, the policies and practices of cosponsors are coordinated through mechanisms like the Committee of Cosponsoring Organizations (CCO); the Programme Coordinating Board (PCB), the primary governance structure of UNAIDS where cosponsors have seats, but no votes; and the Unified Budget and Workplan (UBW), which specifies the division of labor among cosponsors. At the regional and country level they are coordinated through the Regional Coordinators, Regional Support Teams, theme groups, the Resident Coordinator system, and the UN Joint Teams on AIDS and, where the individuals are strong and active, through the UNAIDS Country Coordinator (UCC).

Although UNAIDS has helped to raise HIV on cosponsors' agendas, division of labor and program management under the CCO have been deemed ineffective in past reviews.⁶⁰ In the view of many individuals consulted at both global and national levels, inadequate leadership by UNAIDS has resulted in power struggles among the various UN bodies and a joint work plan that does not adequately delineate responsibility. This causes some issues to have multiple owners—for example, prevention of mother-to-child transmission (MTCT), which falls under the mandate of a number of cosponsors. The result has been duplication of effort, unhealthy competition for funding, and gaps in some areas.⁶¹

A 2007 review of UN progress toward meeting Millennium Development Goal (MDG) 6, target 7 (to have contained the spread of HIV by 2015), recommends that UNECOSOC review and strengthen the UNAIDS mandate, including enhancing Secretariat authority to lead and ensure accountability among cosponsors.⁶² This might include examining further the delineation of responsibility in the UBW, a document in which ownership for nearly every output is joint.⁶³ The working group recommends

that UNAIDS examine mechanisms for clarifying division of labor between the UNAIDS Secretariat and the cosponsors in a way that recognizes the unique contributions of the organizations involved. Suggestions for further improvements in this area are made in a later section.

In addition, the working group recommends that UNAIDS explore more ways to build in-country capacity to help countries “corral the donors” so they provide complementary support for the national priorities and plans developed with genuine civil society involvement. This might, in part, be realized through the “Delivering as One” UN reform initiative, which in eight countries is testing principles of how the UN family can be better coordinated at the country level.⁶⁴ These efforts are in their early stages; Tanzania, however, has documented progress in aligning UN and government financial and planning cycles. At the same time, the Tanzania experience has revealed challenges in shifting a project-based UN system to a unified, policy advisory role.⁶⁵ UNAIDS should participate actively in this process and analyze and disseminate lessons about what is occurring at the country level, including how this process is affecting its operations and interactions with civil society and governments. Moreover, UNAIDS can develop, promote, and apply performance evaluation methods related to coordination for its staff and staff of other UN entities.

Outside UNAIDS unique contributions have been made by major donors, such as the Global Fund and U.S. PEPFAR. While countries have the ultimate authority—though often not the capacity—to coordinate their own AIDS responses, fragmentation can be addressed, in part, by developing more concrete arrangements between institutions in a way that recognizes complementarities. The recent Memorandum of Understanding between UNAIDS and the Global Fund, for instance, recognizes

60. UNAIDS 2002a, b.

61. Yussuf 2007.

62. Yussuf 2007.

63. UNAIDS 2008a.

64. United Nations 2006. These countries include Albania, Cape Verde, Mozambique, Pakistan, Rwanda, Tanzania, Uruguay, and Vietnam.

65. Office of the United Nations Resident Coordinator in Tanzania 2008.

the unique financial resource strengths of the Fund and UNAIDS advocacy and capacity-building linkages on the ground. It sets out a mutual intent to collaborate on a number of overarching objectives that include universal access, inclusive national leadership and ownership, improved aid effectiveness, advocacy, and partnerships.⁶⁶

Even with redoubled efforts, it is likely that making progress on promoting coordination within the UN system, and among external partners, will remain difficult. Each agency has a strong incentive to follow its own narrow mandate and to show success in its own targets, without necessarily contributing to broader collective goals. The result is that individual agencies jealously guard their own turf and spawn their own new initiatives. Staff are rewarded for promulgating narrow agency goals but not for contributing to the broader collaborative goals. In light of this, the working group believes that the UNAIDS Secretariat must constantly highlight the agreed overall collective goals and remind cosponsors and other collaborating partners of them and should establish clear milestones and performance criteria to track the contributions of individual agencies and their staff's progress toward these goals. This role would be consistent with broader UN reforms toward "One UN."

7. Examine the structure, management, and operations of UNAIDS

If UNAIDS is to fully succeed in encouraging accountability, fostering coordination, providing a trusted source of evidence-based policy guidance, and supporting capacity building for voice and action, then a careful look at the structure, management, and operations of UNAIDS is needed. Criticism and suggestions for improvement were heard during interviews and consultations across the four areas highlighted below. The working group suggests that a more in-depth organizational assessment occur across these areas in Mr. Sidibé's first year of office (by January 2010). This assessment will

provide a tool for the UNAIDS Secretariat and the PCB to achieve recommendations that have already been outlined in this report.

- *Make the governing board more transparent and representative of those most affected.*

The PCB is arguably one of the most innovative governance mechanisms in the UN system due to its wide-ranging membership, notably from organizations of people living with HIV and other nongovernmental organizations (NGOs).⁶⁷ But it should assess its current transparency by ensuring that information about staffing numbers and roles is in the public domain. At a minimum, the Secretariat and program could match the disclosure policies of other international organizations such as the Global Fund.

The PCB should also examine how it might align more effectively with the governing bodies of cosponsors, by taking a careful look at the CCO and alternative options for coordination. One proposal was for the Secretariat to include employees from the cosponsoring agencies, rather than employees only of a separate entity.

There are also several ways to enhance representation on the PCB. One is to allow permanent seats for hyperendemic countries that wish to join. A second is to better support civil society organizations in interactions with the PCB, for example, through pre-briefings. A third, discussed at the December 2008 PCB meeting, might be to include members of civil society in national delegations to the PCB, in addition to the current representation of NGOs on the board.⁶⁸

66. UNAIDS and Global Fund to Fight AIDS, Tuberculosis and Malaria 2008.

67. The PCB comprises representatives of 22 governments from all geographic regions, the UNAIDS Cosponsors, and five representatives of nongovernmental organizations, including associations of people living with HIV; civil society representatives do not have voting rights. For composition of the PCB see http://data.unaids.org/pub/InformationNote/2009/pcb_members_updated_en.pdf; for full Modus Operandi for PCB and TOR for CCO see http://data.unaids.org/Governance/PCB01/mojune99rev_en.pdf.

68. See resolutions from 23rd PCB at http://data.unaids.org/pub/InformationNote/2008/20081208_pcb_23_decisions_en.pdf.

- *Improve the coordination framework for joint funding, priority setting, and implementation.*

UNAIDS Unified Budget and Workplan (UBW) is a unique planning tool for activities across the cosponsors and Secretariat.⁶⁹ But having made few real gains on coordination, the UBW appears to be insufficient.⁷⁰ While it applies mechanisms such as Results-Based Management (RBM) in principle, it was noted that there are no documented examples where funds have been withheld from underperforming agencies. This violates some of the well established preconditions for success of an RBM approach.⁷¹ The UBW should pay more attention to clear metrics, milestones, divisions of responsibility, and consequences.

UNAIDS might move toward funding by core contributions so that the influence of donors would be muted preventing politicking on such controversial issues as needle exchange and rights of sex workers. UNAIDS could also explore alternative financial opportunities and consider moving to longer-term planning. The PCB is moving to a four-year planning cycle.⁷² This would create alignment with the current planning cycles of 7 of 10 cosponsors and allow UNAIDS to plan for commitments over a longer time frame, strengthening the core functions discussed above.

69. The UBW combines the work of the 10 cosponsors of UNAIDS and the Secretariat in a biennial budget and workplan. Its aim is to maximize the coherence, coordination, and impact of the UN's response to AIDS. In theory, the UBW ensures unified and coordinated action around joint priorities and results delivered in a framework for joint implementation. For more information see UNAIDS 2008a.

70. Yussuf 2007.

71. UNDG 2009.

72. See meeting notes from 22nd PCB (http://data.unaids.org/pub/InformationNote/2008/20080216_item_7_ubw_cycle_final_en.pdf); information note on 2007–2011 Strategic Framework (http://data.unaids.org/pub/InformationNote/2008/20081031_strategicframework_final_en.pdf); and draft resolutions from 23rd PCB (http://data.unaids.org/pub/InformationNote/2008/20081208_pcb_23_decisions_en.pdf).

- *Institute robust mechanisms for further independent, scientific technical review and oversight.*

While UNAIDS already hosts working groups and reference groups,⁷³ it might be able to leverage the use of independent scientific councils or research advisory boards, as was done in other areas with the formation of the Inter-Governmental Panel on Climate Change (IPCC) and the Strategic Advisory Group of Experts (SAGE) of the WHO Vaccines and Biologicals program.

It was also suggested during the consultation process that UNAIDS needs to be more responsive to local epidemics and research agendas driven by local researchers working at the country level. One suggestion was to create regional research hubs and strengthen relationships with underused WHO Collaborating Centres. For instance, the relationship with HEARD, at the University of KwaZulu-Natal, is underused. Information collected at these regional hubs could then be integrated at the global level.

- *Align the staffing in Geneva and in country with the institutional mission.*

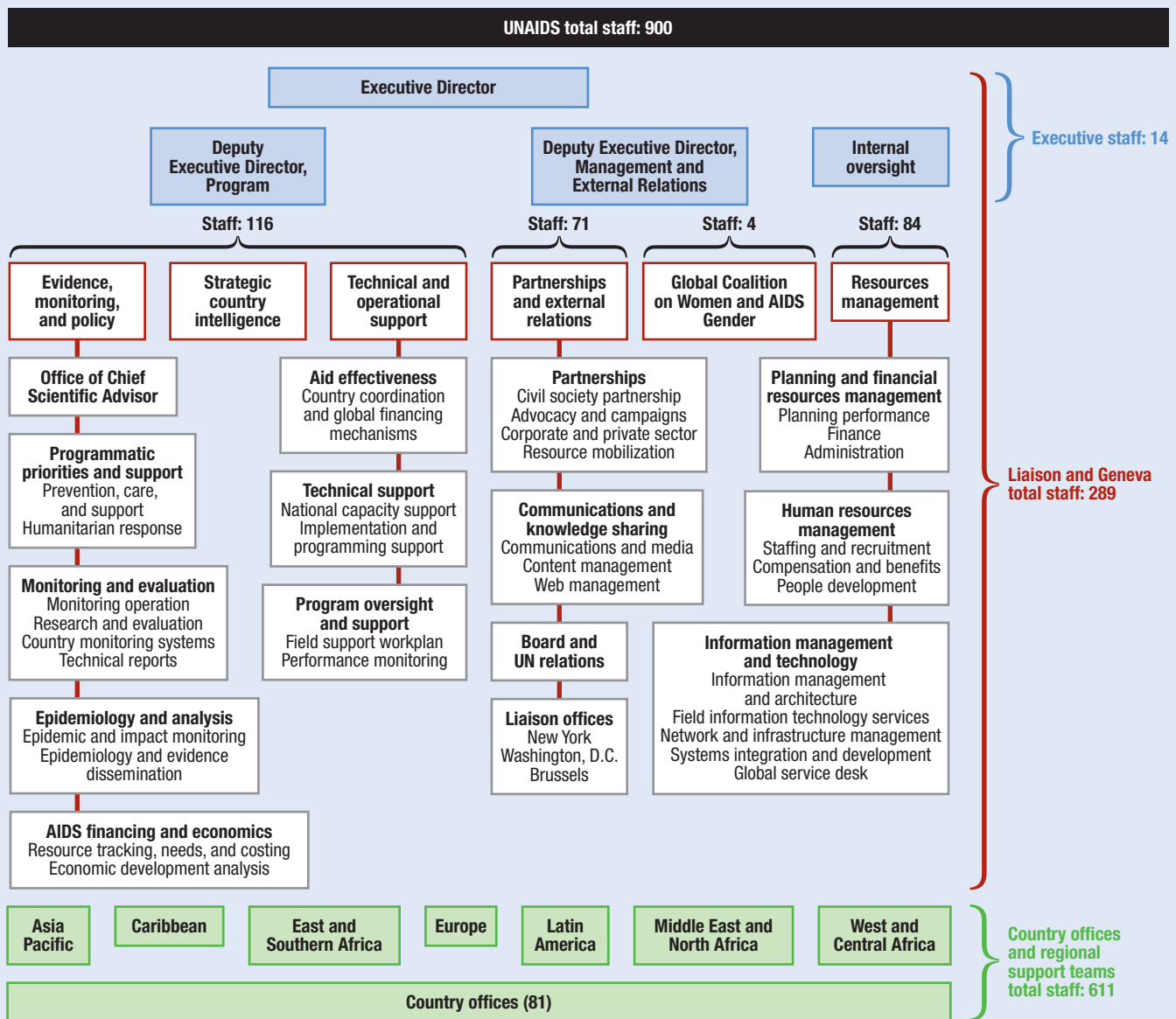
One of the most consistent suggestions heard throughout consultations was the need for the UNAIDS Secretariat to be “right-sized.” The organization is perceived by some observers as larger than is needed to fulfill core functions, with particular concerns about the number of staff working at the Geneva headquarters (see figure 1 for current organizational structure as well as staff numbers). Reduction or other changes in size and reorientation of expertise may be needed at headquarters and regional and country levels so that the structure of UNAIDS meets its focused priorities and functions.

73. For example, see UNAIDS/WHO Working Group on Global HIV/AIDS and STI surveillance at www.unaids.org/en/KnowledgeCentre/HIVData/Epidemiology/epi-workinggrp.asp. For membership of the UNAIDS Reference Group see www.unaids.org/en/KnowledgeCentre/HIVData/Epidemiology/.

Based on issues raised during interviews and consultations, this alignment might examine appropriate skill mix, epidemic knowledge, and UN staff designation commensurate to responsibilities and need in both the Secretariat and the cosponsors. This would include a critical examination of how staffing can be tailored in country and a sense of realism about how one country may require robust support and the presence of UNAIDS while another may

require only limited support, and yet another may require no UNAIDS presence at all. It was also suggested that staff may undertake cross-agency secondments (starting at one agency and rotating between UN agencies before eventually returning to where one began), to facilitate greater institutional harmonization, to harbor a better sense of a “One UN” perspective, and to build a career path that enables greater levels of professional options.

Figure 1 **Organizational structure of UNAIDS in Geneva**



Staffing numbers are approximate and take into account all fixed-term and short-term staff working for UNAIDS, including staff through WHO and UNDP contracts, interns, staff on leave, and replacement staff. UN volunteers, consultants, and cosponsor staff are excluded as recruited on different terms and conditions. WHO provides administrative and financial services for UNAIDS. UNAIDS staffing budget: 10% of staff funded from extrabudgetary resources, approximately 35% at headquarters and regional support team level, including Junior Professional Officers, and 55% at country level. The total full-time equivalent staff working on HIV/AIDS in the UN system represents a 64% increase over the previous two years.

Moving forward

Leadership transitions are volatile periods, signaling uncertainties for staff and partners. At UNAIDS managing the transition will require Michel Sidibé to balance continued daily operations in the Secretariat and work with cosponsors with bold, decisive changes across the organization. Following the first Executive Director of UNAIDS will be difficult. But Mr. Sidibé's eight years of insider experience make him a formidable figure at the Secretariat. His experience gives him knowledge of the organization's internal workings that can contribute to an effective reshaping of the UNAIDS mission and includes a nuanced understanding of the limits to addressing organizational and governance issues more broadly symptomatic of the UN system. Sidibé will need to contribute to a debate on the process of UN reform and reflect on how that may impinge on the work of UNAIDS. The United Nations reform is grounded in the principles of harmonization outlined in the Paris and Accra Declarations. This reform will likely affect UNAIDS, requiring an assessment of how the organization interacts with those in the United Nations and with a fragmented group of external global health actors who work on HIV. In this context it is even more vital to clarify the precise mission and purpose of UNAIDS.

The working group believes that the core mission of UNAIDS should be to use its status and strategic connections as a UN entity to press governments to uphold their existing commitments and to take on new ones that reflect approaches to containing and treating the AIDS epidemic that are at once grounded in scientific evidence and human rights. It should lead by example—in working with those most affected by HIV

and AIDS; in ensuring well coordinated global efforts; and in embedding responses in a long-term strategy informed by national government and civil society perspectives.

The recommendations in this report provide guidance on how UNAIDS might better achieve this mission, while recognizing the undiminished importance of this unique joint program.

Joanne Csete is assistant professor of health and human rights at Columbia University Mailman School of Public Health and director of the Policy and Law Program of the Department of Population and Family Health. She was previously the director of programs and interim executive director at the Firelight Foundation, responsible for managing Grantmaking, Monitoring, Evaluation and Technical Assistance, and Advocacy Programs. Before that Csete was the Executive Director of the Canadian HIV/AIDS Legal Network, one of the world's leading organizations working on legal and human rights issues related to HIV/AIDS. She founded and directed the HIV/AIDS and Human Rights Program at Human Rights Watch in New York, where she oversaw research and advocacy on a wide range of human rights violations related to the AIDS epidemic, including abuses suffered by children affected by HIV/AIDS. She also worked for UNICEF for more than seven years, including as Chief of Policy and Programs at the UNICEF Regional Office for Eastern and Southern Africa.

Csete lived in sub-Saharan Africa for more than 10 years, working on a range of health and nutrition programs for children and women. She was also on the faculties of International Development Studies and Nutritional Sciences at the University of Wisconsin–Madison for five years.

Siddharth Dube is a senior fellow at the World Policy Institute. A writer and commentator on poverty, public health, and development, Dube's books include *In the Land of Poverty: Memoirs of an Impoverished Indian Family, 1947–1997* and *Sex, Lies and AIDS*. He is currently working on a historical account of AIDS in India, to be published in 2010.

Dube was born in Calcutta in 1961. He studied at Tufts University, the University of Minnesota's School of Journalism, and the Harvard School of Public Health, where he completed his MS in 1991. He has since been scholar-in-residence at Yale University's center for interdisciplinary research on AIDS and a long-term visiting fellow at the Centre for the Study of Developing Societies, Delhi. He has been awarded research grants by the Ford Foundation and the U.S. Institute of Peace.

Dube has worked and consulted for the World Bank, UNICEF, WHO, and other international organizations, most recently as senior advisor to the executive director of UNAIDS.

In 2006 Dube, the writer Vikram Seth, and the historian Saleem Kidwai initiated a campaign by prominent Indians to decriminalize same-sex relations. In 2003 he helped organize the first-ever conference on the UN system's responsibilities for protecting the rights of sexual minorities.

Dr. Tim Evans, of Canada, is the Assistant Director-General for Information, Evidence, and Research. Previously, Evans was the Assistant Director-General for Evidence and Information for Policy. He has a bachelor of social sciences from the University of Ottawa and a doctor of philosophy in agricultural economics from the University of Oxford, as well as a doctor of medicine from McMaster University in Canada.

Evans trained in internal medicine at the Brigham and Women's Hospital at Harvard University. He was an assistant professor of international health economics at the Harvard School of Public Health. From 1997–2003 Evans was Director of Health Equity at the Rockefeller Foundation.

Jacob Gayle began working with the Ford Foundation in 2005, as deputy vice president, to serve as a focal point for the Foundation's Global HIV/AIDS Initiative. He also maintains adjunct associate professor status at the Emory University Rollins School of Public Health. During his 16-year career through the U.S. Centers for Disease Control and Prevention (CDC) prior to arrival at Ford, Gayle served as Special Assistant to the Director/HIV for matters pertaining to United States racial and ethnic minority populations and for HIV-related social and behavioral interventions (1989–91). At the direct request of former U.S. President Jimmy Carter, Gayle served as Health Secretariat for The Atlanta Project at the Carter Center (1991–92). Thereafter, as a CDC senior public health officer in global health, Gayle completed interagency assignments at the U.S. Agency for International Development (USAID), Joint United Nations Programme on HIV/AIDS (UNAIDS), United Nations Development Program (UNDP), and World Bank and was assigned to U.S. embassies and missions in Barbados, South Africa, Switzerland, and Trinidad and Tobago. He has authored several refereed publications within the field of public health and HIV/AIDS throughout his professional career and continues to receive awards and recognition for his service in global health and more specifically, HIV/AIDS. Following his BS at Oberlin College (Psychobiology) in 1979, Gayle completed an MS in preventive medicine, an MA in health education/community health, and a PhD in community and international health, all from Ohio State University, before becoming an Associate Professor in community and international health at Kent State University (1985–89).

Jim Yong Kim, MD, PhD, holds appointments as François Xavier Bagnoud Professor of Health and Human Rights at the Harvard School of Public Health and Professor of Medicine and Social Medicine at Harvard Medical School. He is chief of the Division of Global Health Equity at Brigham and Women's Hospital, a major Harvard teaching hospital; director of the François Xavier Bagnoud Center for Health and

Human Rights; and chair of the Department of Global Health and Social Medicine at Harvard Medical School. Kim is currently leading a new Harvard University-based initiative in Global Health Delivery designed to discover and share knowledge about the effective implementation of health programs in poor countries. Kim returned to Harvard in December 2005 after a three-year leave of absence at the World Health Organization (WHO), where he was director of the WHO's HIV/AIDS department and advisor to the WHO director-general.

Kim has 20 years of experience in improving health in developing countries and trained dually as a physician and medical anthropologist. He received his MD and PhD from Harvard University. Kim has been recognized on numerous occasions as a global leader and distinguished professional, including being awarded a MacArthur "Genius" Fellowship in 2003; being named one of America's 25 best leaders by *US News & World Report* in 2005; and being named one of the 100 most influential people in the world by *Time* magazine in 2006.

Danielle Kuczynski (program coordinator) joined the Center for Global Development in September 2007. Prior to joining the Center, Kuczynski worked in Tanzania with the University of Toronto's HIV/AIDS Initiative–Africa as a Knowledge Network Officer. In addition to other overseas experience, her work in the public sector includes a 2006 Policy Analyst post with the Ontario Ministry of Health Promotion. In 2005 Kuczynski completed an MS in international health policy at the London School of Economics and Political Science where she wrote her dissertation on examining perceived barriers to antiretroviral adherence in South Africa. Additionally, she holds a BS in honors psychology from the University of Western Ontario.

Ruth Levine (chair), vice president for programs and operations and senior fellow at the Center for Global Development, is a health economist with more than 15 years of experience designing and assessing the effects of social sector programs in Latin America, Eastern Africa, the Middle East,

and South Asia. Before joining CGD, Levine designed, supervised, and evaluated loans at the World Bank and the Inter-American Development Bank. Between 1997 and 1999, she served as the advisor on the social sectors in the office of the executive vice president of the Inter-American Development Bank.

Levine has a doctoral degree in economic demography from Johns Hopkins University and is the co-author of the books *The Health of Women in Latin America and the Caribbean* (World Bank 2001) and *Millions Saved: Proven Successes in Global Health* (CGD 2004), which has been updated with a new edition as *Cases in Global Health: Millions Saved* (Jones and Bartlett 2007). She has also authored major reports, including *A Risky Business: Saving Money and Improving Global Health through Better Demand Forecasting* (CGD 2007), *When Will We Ever Learn: Improving Lives through Impact Evaluation* (CGD 2006), and *Making Markets for Vaccines: Ideas to Action* (CGD 2005).

Michael H. Merson is the founding director of the Duke Global Health Institute, Wolfgang Joklik Professor of Global Health, and Professor of Medicine, Community and Family Medicine, and Public Policy at Duke University. He joined the Duke faculty in November, 2006. Merson also served as the first Dean of Public Health at Yale University School of Medicine from 1995–2004, and in 2001 he was named as the Anna M. R. Lauder Professor of Public Health in the Yale University School of Medicine. From 1999–2006 he also served as Director of the Center for Interdisciplinary Research on AIDS at Yale University.

In 1978 he joined the World Health Organization (WHO) as a Medical Officer in the Diarrheal Diseases Control Program. He served as director of that program from January 1980 until May 1990. In August 1987 he was also appointed Director of the WHO Acute Respiratory Infections Control Program. In May 1990 he was appointed Director of the WHO Global Program on AIDS. This program was operational worldwide and responsible for mobilizing and coordinating the global response to the HIV/AIDS pandemic.

Merson has authored more than 175 articles, primarily in the area of disease prevention. He currently serves in advisory capacities for UNAIDS; the Global Fund to Fight AIDS, Tuberculosis and Malaria; the World Bank; and the Doris Duke Foundation. He is a member of the Bill & Melinda Gates Foundation's Global HIV Prevention Working Group and has served on several NIH review panels and advisory committees.

Lillian Mworeko, a Ugandan HIV-positive woman, currently working with the International Community of Women living with HIV (ICW, East Africa), has worked with many networks at the national level. She has been involved at international, national, and regional levels in advocacy for the rights of people living with HIV and AIDS and is a human rights activist.

Nandini Oomman joined CGD in March 2006 as the director of the HIV/AIDS Monitor, which tracks the effectiveness of the three main aid responses to the epidemic: the Global Fund, the HIV/AIDS Africa MAP program of the World Bank, and the U.S. President's Emergency Plan for AIDS Relief. Oomman manages the initiative and oversees much of the research program that underpins it. She has more than 15 years of public health research, program, and policy experience, with emphasis on population, reproductive health, and HIV/AIDS.

Before receiving her doctorate from the Johns Hopkins University School of Public Health, Oomman managed an urban HIV/AIDS prevention program for commercial sex workers and college youth in Mumbai, India, and led the technical development of an HIV/AIDS mass media campaign in the same city. In 1996 a post-doctoral fellowship took her to the Rockefeller Foundation where she managed technical assistance for a research grants program on improving reproductive health service delivery in Asia and sub-Saharan Africa. From 2002–04 Oomman worked as a specialist in population, reproductive health, and HIV/AIDS issues at the World Bank. Just before joining CGD, she consulted with private foundations in the United States as an independent researcher.

She has published widely on issues concerning reproductive and women's health.

Nana K. Poku is a John Ferguson Professor of African Studies at the University of Bradford. He joined the University's Peace Studies Department in 2006 from the United Nations where he held the posts of Senior Policy Advisor to the Executive Secretary of the Economic Commission for Africa (ECA) and Director of Research for the United Nations Secretary General's Commission on HIV/AIDS and Governance in Africa (UN-CHGA). He currently serves as a Special Advisor to the Government of Ghana on Poverty Reduction Strategy Papers and health issues and has led 14 appraisal missions in 11 countries in Africa. He has also been an advisor to the European Union, the World Bank, the OECD, the World Health Organization, and the United Nations Development Program, among other international agencies.

Before joining the United Nations, Poku taught and researched on the impact of HIV/AIDS and human security issues in Africa at Southampton University, UK. His research interests include the links between health and political instability, poverty and vulnerability, globalization and inequality, and conflict and children in Africa. On these issues, he has authored and coauthored more than 50 scholarly articles in refereed journals and has written and edited 12 books.

Geeta Rao Gupta has been president of the International Center for Research on Women (ICRW) since 1997. Prior to becoming president, she held a number of positions with ICRW, including consultant, researcher, and officer. She is frequently consulted on issues related to AIDS prevention and women's vulnerability to HIV and is a dynamic advocate for women's economic and social empowerment to fight disease, poverty, and hunger.

Gupta served as co-chair of the UN Secretary General's High Level Panel on Youth Employment and co-chaired the UN Millennium Project's Task Force on Promoting Gender Equality and Empowering Women from 2002–05. She also serves as an advisor to the

UNAIDS Global Coalition on Women and AIDS. Gupta was the recipient of the 2007 *Washington Business Journal's* "Women Who Mean Business" award and is frequently recognized for her commitment to quality research and dedication to the protection and fulfillment of women's human rights.

Gupta is regularly sought out by the development community and media and has been quoted by *The Washington Post*, *The New York Times*, and *USA Today*, as well as other national and international news sources.

Asia Russell has worked extensively as part of the U.S. and international AIDS activist movements over the last 12 years, focusing on treatment access, particularly among low-income people and other marginalized groups. She is currently the director of International Policy for Health GAP, a U.S.-based activist NGO founded in 1999 to close the gap in access to affordable AIDS medicines between developing and developed countries. Health GAP campaigns for the resources necessary to sustain access to AIDS treatment for all, with a focus on the role of U.S. policies in obstructing sustainable access to lowest-cost AIDS treatment.

Since 1995 Russell has also been an organizer and member of ACT UP Philadelphia, the largest grassroots AIDS activist organization in the United States. Russell has coordinated the efforts of successful ACT UP campaigns on issues ranging from national AIDS drug pricing policies to health care justice for U.S. prisoners and detainees with AIDS or hepatitis C. Russell also serves as a board member representing northern NGOs to the board of the Global Fund to Fight AIDS, Tuberculosis and Malaria and on the Global Fund's Policy and Strategy Committee.

Devi Sridhar (senior researcher) is a post-doctoral fellow in politics at All Souls College, Oxford. She also directs the GEG's Global Health Project and is a Senior Research Associate at Oxford's Centre for International Studies. She has worked with a number of UN agencies, civil society organizations, and ministries of health in emerging and developing countries.

Sridhar is the author of *The Battle Against Hunger: Choice, Circumstance and the World Bank* (2008, foreword by Amartya Sen) and editor of *Inside Organisations: South Asian Case Studies* (2008). She holds a PhD and MPH from Oxford and a BS from the University of Miami.

Todd Summers is a Senior Program Officer for Global Health at the Bill & Melinda Gates Foundation. His primary responsibility is leading the foundation's advocacy efforts on HIV, including work on supporting the Global HIV Vaccine Enterprise and the Global Fund to Fight AIDS, Tuberculosis and Malaria.

Before joining the staff in February 2005, Summers was president of Progressive Health Partners, a D.C.-based consulting firm he founded in 2000, specializing in public health policy. Principal clients included the Bill & Melinda Gates Foundation, the Kaiser Family Foundation, and the University of California, San Francisco.

From 1997 to 2000 Summers was the deputy director of the White House Office of National AIDS Policy. While there, he helped coordinate the nation's HIV/AIDS programs among the many federal agencies involved and served as principal liaison to President Clinton's Advisory Council on HIV/AIDS. He also worked closely with the Office of Management and Budget to support increased funding for HIV prevention and care.

Before coming to Washington, Summers was the executive director of AIDS Housing Corporation, a nonprofit organization he helped found in 1990 to develop supported housing programs for people living with HIV. Summers has also held senior positions in the affordable housing and commercial real estate development fields. He has a BA cum laude in Religion from Middlebury College in Middlebury, Vermont.

Alan Whiteside was born in Kenya and grew up in Swaziland. In 1980 he obtained an MA in Development Economics from the University of East Anglia, and in 2003 a DEcon from the University of Natal. In 1998 he established the

Health Economics and HIV/AIDS Research Division (HEARD) at KwaZulu-Natal University, where he is now Professor of Health Economics and the Director of this division. For 10 years (1983–94) he worked as Research Fellow/Senior Research Fellow for the Economic Research Unit, University of Natal (now University of KwaZulu-Natal). Before that, he worked as an Economist for the Overseas Development Institute in the Ministry of Finance and Development in Gaborone, Botswana. He is the author of numerous articles and books, most recently *HIV/AIDS: A Very Short Introduction* (2008). He was a Commissioner on the UN Commission on HIV/AIDS and Governance in Africa and is the elected treasurer of the International AIDS Society Governing Council. He is also a Governor of Waterford Kamhlabe United World College in Swaziland.

Ngairé Woods (chair) is Professor of International Political Economy and Director of the Global Economic Governance Programme at Oxford University. She was educated at Auckland University (BA in economics, LLB Hons in law). She studied at Balliol College, Oxford, as a New Zealand Rhodes Scholar, completing a MPH in International Relations (with distinction) and a DPhil. She won a Junior Research Fellowship at New College, Oxford (1990–92) and subsequently taught at Harvard University (Government Department) before taking up her Fellowship at University College, Oxford. In 2003 she founded a research program investigating how global institutions could better respond to the needs of developing countries—the Global Economic Governance Programme. Her recent books include *The Politics of Global Regulation* (with Walter Mattli, 2009), *The Globalizers: the IMF, the World Bank and their Borrowers* (2006), *Exporting Good Governance: Temptations and Challenges in Canada's Aid Program* (with Jennifer Welsh, 2007), and *Making Self-Regulation Effective in Developing Countries* (with Dana Brown, 2007).

Anandi Yuvaraj is the Asia Pacific Regional Coordinator of the International Community of Women Living with HIV/AIDS (ICW),

based in Bangkok. Before joining the ICW, Yuvaraj worked as Program Manager for HIV and Sexual Reproductive Health at PATH's India office, where she managed an advocacy project of the Global Campaign for Microbicides (GCM) in India. She was also employed by the International HIV/AIDS Alliance in India as Senior Programme Officer for more than five years. During this tenure she got involved with the Global Fund to Fight AIDS, Tuberculosis and Malaria as the Board Representative of the Communities Delegation (2004–06).

She is also a member of the national advisory board of the Indian chapter of the International AIDS Vaccine Initiative. In addition, she served as a steering committee member, advising the development of national strategies for phase III of the National AIDS Control Programme (NACP) in India. Yuvaraj serves on the board of the International Partnership on Microbicides (IPM) as well.

Since testing HIV-positive in 1997, she has played a vital role in broadening political and social responses to the epidemic in India. She began her work by establishing a local organization to support fellow people living with HIV in her community, which continues to be a strong and effective program. She has been instrumental in mobilizing communities affected by HIV/AIDS to raise their voices, needs, and concerns to build supportive environments. Yuvaraj has played a crucial role in mobilizing the civil society in India to influence the NACP-III through national level consultations.

Yuvaraj obtained a masters in zoology from Madras University in Tamil NADU, India, with a specialization in fishery biology. She completed her thesis from the same university for a masters in philosophy. She has gained strong experience in the policy, advocacy, and program and financial management of HIV and AIDS programs at various levels.

Participants in background interviews

Alanna Armitage, UNFPA Country Representative for Brazil	Jim Kim, Harvard University
Stefano Bertozzi, Mexico National Institute of Public Health	Rose Kumwenda-Ng'oma, Christian Health Association of Malawi
Agnes Binagwaho, Permanent Secretary for Health in Rwanda	Stephen Lewis, AIDS-Free World
Pierre Blais, Permanent Mission of Canada to the UN, Geneva	Margaret Lidstone, Office of the U.S. Global AIDS Coordinator
Jonathan Brown, World Bank	Collin McIff, Office of the U.S. Global AIDS Coordinator
Pedro Chequer, UNAIDS Country Coordinator, Brazil	Jeffrey Mecaskey, Save the Children UK
Alex de Waal, Harvard University	Michael Merson, Duke University
Siddharth Dube, World Policy Institute	Lazeena Muna, UNAIDS Bangladesh
Simone ellisOluoch-Olunya, UNAIDS Darfur	Leonard Okello, ActionAid
Roger England, Health Systems Workshop, Grenada	Nandini Oomman, Center for Global Development
Helen Epstein, Author	Jeff O'Malley, UNDP
Helene Gayle, CARE USA	Mead Over, Center for Global Development
Jacob Gayle, Ford Foundation	Elizabeth Pisani, Author
Adrienne Germain, International Women's Health Coalition (written correspondence)	Beth Plowman, Independent Consultant
Joana Godinho, World Bank	Miriam Rabkin, Rockefeller Foundation/Columbia University
Daniel Halperin, Harvard School of Public Health	Geeta Rao Gupta, International Center for Research on Women (ICRW)
Robert Hecht, Results for Development	Jaime Sepulveda, Bill & Melinda Gates Foundation
Carrie Hessler-Radelet, John Snow International	Jeremy Shiffman, Syracuse University Maxwell School of Public Policy
Omokhudu Idogho, ActionAID	Francisco Songane, WHO Maternal/Perinatal Partnerships
Andrew Jack, Financial Times	Anil Soni, Clinton Foundation
Jennifer Kates, Kaiser Family Foundation	John Stover, Futures Institute

Todd Summers, Bill & Melinda Gates
Foundation

Keizo Takemi, Harvard School of Public Health

Abel Viquez, Joint Commission Against
AIDS, Costa Rica

Derek von Wissell, NERCHA, Swaziland

Gill Walt, London School of Hygiene and
Tropical Medicine

Alan Whiteside, University of KwaZulu-Natal

Desmond Whymys, HLSP

Roy Widdus, Global Health Futures

Paul Zeitz, Global AIDS Alliance

Summary of consultations for UNAIDS working group and participants

The following section summarizes the discussions and recommendations that emerged over the course of the three consultation meetings in Washington, D.C. (Center for Global Development), Oxford (Global Economic Governance Programme), and Durban (University of KwaZulu-Natal).

Washington consultation summary, October 15, 2008

This section summarizes general themes, key points, and ongoing considerations emerging from discussions held October 15, 2008, in Washington, D.C. at a meeting convened by the Center for Global Development to bring together experts on HIV/AIDS, global health, and governance to discuss the future of UNAIDS and in particular the functions and areas the next Executive Director should address.

General themes

A number of key points were raised during the consultation meeting in Washington, D.C. The discussion focused generally on some of the roles that UNAIDS should both assume and retain as well as on drawing out questions that need to be considered if the organization were to re-evaluate its purpose in the future. Some of these considerations relate to issues that UNAIDS will be unable to address on its own: they reflect larger debates that should be addressed by the global health and HIV/AIDS communities at large.

Key roles for UNAIDS

- Improve evidence base and policy response to prevention in an environment that has been focused as of late on treatment, causing

a de-emphasis on prevention and most at-risk populations.

- Build appropriate technical capacity and leadership within the program at the country level.
- Engage with leading funders (Global Fund, PEPFAR).
- Engage with and build civil society capacity; an important measure of success will be how effectively it can do this across different groups and in different country contexts.
- Be leaner and meaner: overall, the organization should become more efficient and effectively and critically assess how it can refocus its current functions.

Ongoing considerations

For UNAIDS.

- History has played a part in driving the formation of the program, and UNAIDS needs to be mindful that this is in part why the organization exists today in its current form.
- UNAIDS should clarify the meaning and role of advocacy with respect to how it functions. Are its reporting functions in conflict with its advocacy role in keeping HIV/AIDS a high global health priority?
- Moving forward, UNAIDS needs to clarify what its role is at the country level.
- Performance indicators: on what basis should success of the organization be judged?
- Governance and alternative structures: how could these better facilitate the necessary functions of the program?

For UNAIDS and other actors.

- Adopt a principle that activities should not have a negative impact on other priority health topics. Logical fallacies with respect

to HIV/AIDS crowding out other global health funding should be avoided.

- Support an international response to ensure commitment to people on treatment.
- Avoid pitting a public health versus human rights response.
- Consider the current context of the financial crisis and what this will mean for development overall and health specifically.

Participants

Olusoji Adeyi, World Bank

Smita Baruah, Global Health Council

Carol Bergman, Global AIDS Alliance

Stefano Bertozzi, Mexico National Institute of Public Health

Natasha Bilimoria, Friends of the Global Fight

Gillian Buckley, Johns Hopkins School of Public Health

Dennis Cherian, World Vision

Joanne Csete, Independent

Paul Davis, Health GAP (Global Access Project)

Robert Eiss, National Institutes of Health

Roger England, Health Systems Workshop, Grenada

Jacob Gayle, Ford Foundation

Andrew Gibbs, University of KwaZulu-Natal

David Gootnick, U.S. Government Accountability Office

Ester Gwan, World Relief

Daniel Halperin, Harvard University

Dale Hanson Bourke, the Center for Infectious Disease Research in Zambia Foundation

Robert Hecht, Results for Development

Jennifer Kates, Kaiser Family Foundation

Jim Yong Kim, Harvard University; Partners In Health

Steve Kraus, UNFPA

Danielle Kuczynski, Center for Global Development

Kristie Latulippe, Center for Global Development

Eric Leif, Henry L. Stimson Center

Noelle Lusane, Office of Congressman Payne

William McGreevey, Constella Group, LLC; Georgetown University

Michael Merson, Duke University

Nadeem Mohammad, World Bank

Stephen Morrison, Center for Strategic International Studies

Nandini Oomman, Center for Global Development

Mead Over, Center for Global Development

Geeta Rao Gupta, International Center for Research on Women

Jessica Raper, Georgetown University

Asia Russell, Health GAP (Global Access Project)

Jeremy Shiffman, Syracuse University

Andrew Small, US Council of Catholic Bishops

Shannon Smith, Office of Senator Richard Durbin (D-IL)

Devi Sridhar, Global Economic Governance Programme, Oxford University

Carl Stecker, Catholic Relief Services

Michele Sumilas, House Subcommittee on State, Foreign Operations and Related Programs

Todd Summers, Bill & Melinda Gates Foundation

Christos Tsentas, Office of Congresswoman Barbara Lee

University College, Oxford, consultation summary, October 27–29, 2008

This section summarizes general themes emerging from discussions held October 27–29, 2008, at University College–Oxford at a meeting convened by the Global Economic Governance Programme and the Center for Global Development to bring together experts on HIV/AIDS, global health, and governance to discuss the future of UNAIDS and in particular the functions and areas the next Executive Director should address.

General themes

Four general points emerged from the discussion. First, UNAIDS is just one of many UN bodies in need of reform. Thus, while the UNAIDS consultation delved into the particular reforms the next Executive Director and the PCB could make, there was general awareness that UNAIDS is working within an existing dysfunctional UN system and chaotic health architecture. A second point underscored by discussions was the key role of individuals and their leadership in this area, both within the UNAIDS Secretariat staff in Geneva and in-country and within the cosponsors. A third point was the importance of enforcing commitments made by donors in the 2005 Paris Declaration and 2008 Accra Declaration and the need to take developing countries' voices into account, especially on issues of coordination and priority-setting. Fourth, it is vital that the UNAIDS Secretariat and cosponsor staff tailor their approach and adapt it to the country context.

UNAIDS core functions

Consensus was reached that UNAIDS should focus on creating and enforcing global commitments and standards rather than operations. First, UNAIDS must hold governments accountable for global commitments already undertaken, such as for universal access commitments. Second, UNAIDS has an equally vital role to play in forging new global standards: UNAIDS should be the gold standard in terms of technical and policy guidance (see next section). Participants noted that UNAIDS should use its legitimacy conferred by UN status to show leadership on HIV/AIDS and strengthen its role as a focal point in the HIV/AIDS response.

UNAIDS activities to achieve core functions

To achieve its core functions, participants listed UNAIDS core activities.

- *Coordinate cosponsors and other key actors.* Participants noted that UNAIDS should not be an agency. It should focus on coordinating the cosponsors in order to leverage

the expertise of each on HIV/AIDS. The cosponsors should produce research and implement programs relevant to HIV/AIDS, and thus UNAIDS should ensure that cosponsors are in continual dialogue with each other. The idea was raised of UNAIDS being given the authority to also coordinate other key actors such as the Global Fund, the Gates Foundation, and PEPFAR. While this may not be an official relation, UNAIDS could use its scientific authority on HIV/AIDS (see next point) to monitor and ensure compliance. Given this new and focused role, one suggestion was put forward to close down all country offices and move to regional representation. A variant on this would be to have country offices only in hyperendemic countries or those with difficult political situations for most at risk groups. Another suggestion was put forward for demand-driven presence of country offices. No consensus was reached on this point, and further discussion is needed.

- *Show leadership and scientific expertise.* All participants agreed that UNAIDS needs to become the scientific expert on HIV/AIDS prevention and treatment, demonstrate best practices in country on what does and does not work, and show real leadership on synthesizing evidence in an independent and rigorous manner. UNAIDS should use its position and legitimacy as a UN agency to say things, backed by evidence, that governments and politicians find difficult to say. Attention was drawn to the terms “science” and “evidence” to indicate that it should not just be biomedical evidence but also social, behavioral, and political evidence. In terms of the epidemiology and surveillance roles, participants felt that this could be given back to the WHO.
- *Use evidence for advocacy.* UNAIDS should not only be a scientific clearinghouse but also make sure that the evidence is used to inform policies by cosponsors, governments, and nonstate actors. This should be underpinned by a strong human rights framework. UNAIDS should provide clear guidance to governments and use the evidence to

advocate on behalf of those most affected by the epidemic.

- *Focus on high-risk groups.* Throughout the consultation, participants continually noted that UNAIDS must focus on the most high-risk groups affected by HIV/AIDS. These include prisoners, injection drug users, men who have sex with men, indigenous communities, and sex workers. The activities as a scientific clearinghouse, use of evidence to advocate, and the focus on high-risk groups were seen as interlinked and central to the future role of UNAIDS. In particular, the next executive director of UNAIDS should work to forge agreements on the following neglected areas: naming groups most at risk, decriminalization, supportive social and legal environments, prisoners, and illicit drug users.

Whom must UNAIDS hold to account?

UNAIDS was seen as needing to play a stronger and more central role in holding various actors to account. These included donor governments, multilaterals, the new programs, and cosponsors. However, to be able to do this, certain organizational changes are necessary to build a strong UNAIDS secretariat.

What must change in order to fulfill core functions?

- *Staffing.* There was general agreement that the UNAIDS Secretariat in Geneva should become leaner and more focused. One suggestion was to cut the Geneva staff to around 40 technically skilled senior staff. More transparency and attention should be given to criteria for staff recruitment, proportionate compensation, and subsequent performance measurement to ensure there is a “strong brain” in Geneva. It was felt that there needs to be more auditing of staff leadership and technical ability, especially in high-priority areas, with clear benchmarks that must be met. The need for country representation was also pointed to as needing further discussion.
- *Funding.* Given that the UNAIDS Secretariat staff numbers, and thus annual budget required, would be reduced, UNAIDS

should work toward a high percentage of core contributions, rather than a reliance on voluntary funds. This was seen as crucial to ensure that UNAIDS can be a strong scientific clearinghouse and play an advocacy role, especially when advocating for more attention to high-risk groups.

- *Transparency.* In addition to transparency on staffing, there was consensus that UNAIDS must make available in a publicly accessible and useful manner its financial record and other internal reports, at least to a level similar to the Bretton Woods institutions.

In terms of next steps, suggestions were given on how best to carry the process further at the consultation in Durban at the University of KwaZulu-Natal with Professor Alan Whiteside. It was felt that there needs to be more input from developing country government officials, specifically from those involved in the day-to-day management of HIV/AIDS, as well as more discussion on whether country offices are necessary, and why.

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Durban, South Africa, consultation summary, November 16–18, 2008

This brief overview summarizes areas of convergence that emerged at the Durban consultation. It is broken down by themes that were discussed over the course of the meeting as well as specific areas of potential focus for UNAIDS.

General themes

- Know your epidemic and its changing nature.
- Recognize that there are multiple epidemics—not just epidemiological but social and economic.
- Remember that HIV/AIDS *is* exceptional in sub-Saharan Africa.
- Support civil society.
- Use local governments to lead.
- Take a long-term view.
- Consider the financial crisis in planning.

Role of UNAIDS

After 25 years of few measurable successes, there is a need to “re-tool” the strategy. UNAIDS needs the following:

- A leaner, more streamlined secretariat in Geneva.
- Increased legitimacy to coordinate activities and open discussion between international actors.
- Articulation of a role to hold donors accountable to commitments.
- To be an advocate for resource mobilization.
- An improved role as a repository for evidence-based policy/practice/advocacy fed by local research and priorities of regions hardest hit by the epidemic.
- Information about the epidemics that goes beyond epidemiology to include social and economic impacts.

Regional role

- Be a neutral broker “with muscle” (at the regional and country level).
- Facilitate sharing of local experience between countries.
- Enhance links to regional mechanisms.
- Strengthen regional bodies and civil society.
- Act as an entry point for policy messages.
- Harmonize regional research hubs.
- Coordinate meaningfully with other official collaborating centers and regional actors and agencies.
- Have a research agenda driven by local epidemics.
- Facilitate information exchange; link to global level.

Country role

- Determine role of UNAIDS by local epidemic, capacity, and level of national response.
- Coordinate UN actors at the country level based on recognized capacity.
- UNAIDS Country Coordinators: choose staff for management and leadership capabilities based on local needs; increase status level of in-country leadership to support their role as a facilitator of multiple actors.
- Bring the “legitimacy” of the United Nations.
- Advocate for scaling up resources.
- Facilitate learning from success and failure.
- Coordinate beyond the UN system.

Role in technical support

- Ensure that technical support facility consultants are high quality and that country feedback meaningfully informs selection; consider Southern African Development Community (SADC) as a potential broker.
- Play a role in linking researchers and key actors and sharing information.
- Be a linker, broker, and capacity builder, but not a competitor to local implementing organizations.

Role in structure

- Form to follow function.
- Refocus Geneva and scale up to reflect worst-hit regions/countries (vertical).

- Shift resources to epidemic countries/regions, proportional to epidemic (horizontal).
- Provide stronger regional and country resources: resources to match scale.

Role in governance

- Increase transparency in selection of PCB (Programme Coordinating Board).
- Consider giving SADC/regional bodies potential observer status (PCB).
- Strengthen representation of affected countries; more permanent seats.
- Give civil society better support in their interactions with PCB: prebriefings and so forth.
- Increase voice while recognizing UN constraints.
- Better prepare regional representatives and hold them responsible (SADC).

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Summary of points of consensus

Washington, D.C./Oxford	Durban
Consider a refocused option	Refocus in Geneva but increase presence at regional level with resources shifted according to need in hyperepidemic countries
Increase technical capacity of the organization	Increase technical knowledge of UNAIDS staff and ensure position of individual is commensurate with their role at the country level; facilitate access to technical capacity in countries and support technical capacity building at regional and national levels
Be an evidenced-based champion: focus on prevention and high-risk groups	Increase focus on prevention, recognizing that in SSA, HIV/AIDS is exceptional and generalized
Be an independent, credible, scientific clearinghouse	Be a scientific clearinghouse at the global level, that is fed by national and regional research priorities
Strengthen role in coordination	Strengthen role in coordination at global, regional, and national levels; including to ensure that civil society has access to these spaces
Strengthen role in upholding commitments to HIV/AIDS	Support civil society in upholding national commitments at global and regional/national level

Background work for this report occurred from July 15, 2008, to December 8, 2008, and consisted of a broad literature review, several semi-structured interviews, and three consultations. A full list of interviewees is in annex B of this report; notes from the consultations can be found in annex C.

Broad literature review

A web-based literature review was conducted in July 2008 through a targeted search using the search terms “UNAIDS” from 1996 until today. Material included peer-reviewed journal articles, grey literature, and internal and external UNAIDS evaluations and publications. The journals covered *Lancet*; *British Medical Journal*; *New England Journal of Medicine*; *American Journal of Public Health*; *Canadian Journal of Public Health*; *European Journal of Public Health*; *World Development*, *Social Science and Medicine*; *Global Governance*; *International Organization*; *New Political Economy*; *Review of International Political Economy*; *Critical Public Health Development in Practice*; *Annual Review of Public Health*; *Health Affairs*; *Journal of Biosocial Science*; *Journal of Health, Population and Nutrition*; *World Bank Observer*; *UN Chronicle*; *Journal of Public Health Policy*; *Anthropology Today*; *Medical Anthropology Quarterly*; *Foreign Affairs*; *World Politics*; *International Studies Quarterly*; *Global Health Governance*; and *International Security*.

In addition, a media review was conducted in August 2008 on the search term “UNAIDS” from 1996 until today, using LexusNexus. Further materials were reviewed as they were identified throughout the consultation process. These included additional articles and media releases, published books, and official documents

and resolutions related to the establishment of UNAIDS.

Semistructured interviews and comments

Interviews were conducted from August 1, 2008, to December 8, 2008. The interviewees included working group members as well as additional individuals collected through snowball sampling. The initial interviewees and the working group members were identified by the researchers on the basis of their experience and unique perspective from both individual and institutional standpoints. This list of interviewees then grew based on recommendations from others, particularly after the background paper was posted. Twenty-nine interviewees contributed their perspectives to the first paper; the number of interviewees consulted in preparation of this document now totals 50. The background interviews helped to provide additional depth and nuance to the recommendations distilled from the consultation process.

The original background paper was also posted online to solicit confidential comments from readers. A total of seven individuals responded through this mechanism; a number of other individuals submitted comments directly to the authors. These comments were taken into consideration in this final report. Where necessary, individuals were followed up with formal interviews; these are listed in annex B.

The authors acknowledge that the set of individuals interviewed for this report may not be fully representative of all affected populations or involved groups; the group was not intended to be exhaustive in scope. We accept responsibility for any shortcomings this may create.

Consultations

Three global consultations were also organized in Washington, D.C. (October 15); Oxford, U.K. (October 27–29); and Durban, South Africa (November 16–18). These consultations aimed to stimulate open and public discussions about the future of UNAIDS, with each focused respectively on stimulating a broad discourse on roles and responsibilities of UNAIDS; bringing academic as well as European perspectives with a focus on governance; and a perspective on the role of UNAIDS at the country level.

The recommendations of this report took shape over the course of this process. Working

group members were invited to participate in all consultation meetings but were strongly encouraged to attend the Oxford meeting as an opportunity to bring members together once over the month in which all three meetings occurred. Two group teleconferences and written feedback received between the Durban consultation and mid-January 2009 provided opportunities for working group members to ensure that the final product reflected their views.

It is acknowledged that recommendations made at the country level throughout this report are biased by a sub-Saharan African perspective; the role that UNAIDS is best suited to fill will vary between countries and regions based on a number of factors.

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