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Religion in the United Nations (UN) Political Declarations on HIV & AIDS: An interdisciplinary, critical discourse analysis

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Abstract

This interdisciplinary cultural studies research uses critical discourse analysis to review the four political declarations on HIV & AIDS adopted by the United Nations in 2001, 2006, 2011 and 2016. Religion is implicated in the tensions and conflicts around issues of HIV and sexual and reproductive health and rights in the negotiations that hinders consensus, resulting in compromises and omissions in the texts. The research identifies four dominant discourses in the declarations and an additional two in the wider HIV response of relevance to these tensions; a public health, biomedical discourse; a human rights, gender equality and community engagement discourse; political discourses of leadership and national sovereignty; and a traditional religio-cultural discourse. In the wider HIV response a broader religious discourse and secularist discourse are evident but missing from the text of the declarations. This critical discourse analysis of the declarations investigates how the discourses interact in the text; how the traditional religio-cultural discourse influences the text; what is missing from the final text; and reasons for the gaps. Close textual analysis of the declarations identifies tension between the public health, human rights/gender equality discourses and the traditional religio-cultural and national sovereignty discourses. The traditional religio-cultural discourse operates to limit public health and rights-based approaches to HIV prevention and frames women and girls as passive victims, without agency to exercise their rights. When compared against UNAIDS strategies as a standard, the declarations are missing commitments to address the risks of key populations to HIV. Missing also is reference to any contributions the faith community brings to the epidemic. The broad religious discourse includes supportive approaches to public health, human rights and gender equality, with the potential to bridge gaps in the negotiations. The traditional religious discourse is implicated in gaps in the text on key populations and rights. The dominance of secularism at the UN is implicated in exclusion of the broad religious discourse. While obstacles around rights-based approaches to HIV prevention and key populations persist, common ground and synergies between the discourses exist. Recommendations include: to ask new questions at the UN about the role secularism plays that may increase space for conservative voices to operate; seeking new ways of working to bridge some of the gaps; and including different perspectives that have the potential to bridge the gaps and open up new ways to achieve consensus.

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Author's Declaration

I declare that this thesis is my own work and that the work has not been submitted for the award of a higher degree elsewhere.

The views and opinions expressed in this thesis are those of the author and do not necessarily represent the policies or positions of UNAIDS

Abbreviations

AIDS	Acquired immuno-deficiency syndrome
ACHAP	African Christian Health Associations Platform
ANERELA+	African Network of HIV-Affected Religious Leaders Living With or Personally Affected by HIV and AIDS
ART	Antiretroviral treatment
ARHAP	African Religious Health Assets Programme
BT	Basic Teaching
CI	Caritas Internationalis
CHART	Collaborative for HIV and AIDS, Religion and Theology
CRC	Convention of the Rights of the Child
CDA	Critical Discourse Analysis
CEDAW	Convention on the Elimination of All Forms of Discrimination against Women
CEGM	Gender Mainstreaming framework of the Council of Europe
CS	Cultural Studies
CSW	Commission on the Status of Women
DoC	Declaration of Commitment
DFID	Department for International Development (UK)
EAA	Ecumenical Advocacy Alliance
ECOSOC	United Nations Economic and Social Council
EHAIA	Ecumenical HIV Initiatives and Advocacy
eMTCT	Elimination of Mother-To-Child Transmission
FBO	Faith-based organization
GA	General Assembly (of the United Nations)
GIN	Global Interfaith Network for People of all Sexes, Sexual Orientations, Gender Identities and Expressions
GNP+	Global Network of People living with HIV
GIPA	Greater involvement of people living with HIV and AIDS
HLM	High Level Meeting
HIV	Human immunodeficiency virus
IATF	Interagency Task Force on Faith and Development
ICW	International Community of Women Living with HIV & AIDS

ICCPR	International Convention on Civil and Political Rights
ICPD	International Council of Population and Development
ICESCR	International Covenant on Economics, Social and Cultural Rights
INERELA+	International Network of Religious Leaders Living With or Personally Affected by HIV and AIDS
JLIF&LC	Joint Learning Initiative on Faith and Local Communities
LGBTI	Lesbian, gay, bisexual, transgender or intersexual
MS	Member States
MSM	Men who have sex with men
MCH	Mother and child health
NLCC	Natural Law theory and the teachings within the Catholic Church Catechism
NGO	Non-governmental organization
NORAD	Norwegian Agency for Development Cooperation
OCHA	The United Nations Office for the Coordination of Humanitarian Affairs
OIC	Organisation of Islamic Conference
PaRD	Partnership for Religion and Development
PLHIV	People living with HIV
PUD	People who use drugs
PD	Political declaration
PT	Practical theology
PEPFAR	President's Emergency Plan for AIDS Relief (US)
PMTCT	Prevention of mother-to-child transmission
POA	Platform for Action
PCB	Programme Coordinating Board
QR	Qualitative researcher
RCT	Rational Choice Theory
RR	Reproductive rights
ROC	Russian Orthodox Church
SAVE	Safer Practices, Available Medications; Voluntary HIV, testing and counselling; Empowerment through education
SW	Sex worker
SPU	Saint Paul's University

SG	Secretary General
SRH	Sexual and reproductive health
SRHR	Sexual and reproductive health and rights
SOGI	Sexual orientation and gender identity
SADC	Southern African Development Community
SDHIV	Stigma and discrimination conceptual framework of Parker and Aggleton
SDGs	Sustainable Development Goals
TRIPS	Agreement on trade-related aspects of intellectual property rights
TB	Tuberculosis
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNGA	United Nations General Assembly
UNHCR	United Nations High Commission for Refugees
UNHRC	United Nations Human Rights Council
UNMEER	United Nations Mission for Ebola Emergency Response
UNSSC	United Nations System Staff College
US	United States
USA	United States of America
UDHR	Universal Declaration of Human Rights
UCT	University of Cape Town
VAW	Violence against women
WEOG	Western European and Others Group
WLHIV	Women living with HIV
WCC	World Council of Churches
WHA	World Health Assembly
WHO	World Health Organization

Chapter 1. Introduction

This chapter outlines the nature of the study and the research methodology. It includes a problem statement, purposes and boundaries of the research, and the key questions to be addressed, explaining the reasons for selection of this research topic, and outlining the chosen research design and methodology. It concludes with a brief indication of the areas in which findings will be demonstrated and from which recommendations will be drawn.

1.1 Assumptions

The following assumptions underlie this research:

- The HIV epidemic is a complex interdisciplinary problem: a public health issue, a socio-political issue, a human rights issue, a gender/sexuality issue, and a religious and theological issue (Smith 2013).
- All of these aspects must be taken into account in order to fully understand and address the HIV epidemic. Such an approach requires an interdisciplinary methodology.
- The public health, socio-political, human rights, gender/sexuality, and religious/theological dimensions of the HIV problem have given rise to and fostered distinct types of discourse on HIV & AIDS.
- An interdisciplinary understanding of HIV & AIDS can be gained through critical discourse analysis of these five thematic areas.

This thesis provides evidence that a religious discourse on HIV has influenced the text of Political Declarations (PDs) on AIDS negotiated and adopted at the United Nations (UN). This influence on the wording of PDs has implications for programming and funding flows and is therefore of great importance for tackling the HIV epidemic.

1.2 Background and context

1.2.1 HIV, AIDS and the United Nations

The human immunodeficiency virus (HIV) and acquired immuno-deficiency syndrome (AIDS) rapidly became a critical public health issue in the 1980s and 1990s. Since HIV was first identified as the cause of AIDS in 1983, approximately 76 million people have been infected, and 35 million have died from AIDS-related illnesses. Despite progress in preventing, diagnosing and treating HIV, it is estimated that 1.8 million people were infected with HIV in 2016, and about 1 million people died from AIDS-related conditions (UNAIDS 2017c). In recent history no other disease has caused such morbidity and mortality in working adults in such a short time, depriving children of parents and countries of their workforce, and becoming one of the greatest public health challenges in history (UNAIDS 2011a). In the late 1990s, AIDS was a major threat across the globe, particularly in Africa, where infection rates were rising at an alarming rate. Between 1981 and 2000 the disease came to affect people from every geographic region; an estimated 27.5 million people were infected (UNAIDS 2011a: 15). The seriousness of the situation was such that there was an unprecedented discussion of HIV & AIDS at the UN Security Council in 2000. In 2001, the General Assembly (GA) of Member States (MS) of the United Nations (UN) met to consider this new disease; the first time that the GA had met in special session to consider any single disease (UNAIDS 2011a: 23).

When the GA meets for a special session on a critical issue, MS generally negotiate and adopt a statement of agreement and commitments, known as a political declaration (PD). These declarations are texts forged through consensus and compromise, arrived at through a process of negotiation over several weeks from an initial ‘zero draft’ of the text, usually prepared by the relevant UN agency. A strong PD can drive country-level programmatic action and influence the direction of donor funding to national HIV responses. This is why they are so important; they demonstrate political commitment to address the epidemic and provide a blueprint for national AIDS plans.

1.2.1.1 Negotiating Political Declarations on HIV & AIDS

To summarize current practice, two countries are nominated by the President of the United Nations General Assembly (UNGA) as co-facilitators, generally one each from the global south and the global north. They work together with staff from the technical agency, the Joint United Nations Programme on HIV/AIDS (UNAIDS) to prepare a 'Zero Draft' of the Political Declaration drawing on the most recent UNAIDS Strategy (developed, from the most recent data available on the HIV epidemic, in consultation with representatives from MS Diplomatic Missions in Geneva, and adopted by the governing board of UNAIDS, which is made up of Geneva-based Diplomatic Mission staff). Diplomatic staff in Geneva are familiar with the technical issues of HIV and Human Rights because the technical agencies (WHO, UNAIDS and the UN Human Rights Council) are located in Geneva. Diplomatic missions therefore place staff with technical expertise in these areas in Geneva and those with political skills in New York.

Over 2-3 weeks the co-facilitators in New York engage in a series of negotiations with Diplomatic Mission staff on the zero draft. To support this process UNAIDS is invited to make technical presentations on the UNAIDS strategy, current data, and answer questions from mission staff. UN staff are not permitted to make any direct inputs to the text during negotiations. The challenge is that diplomatic mission staff in New York are not technical experts in health and human rights but are very familiar with the longstanding and oft repeated disagreements through rounds of negotiations on sexual and reproductive health, commonly known as 'culture wars'. Negotiations, around controversial and sensitive issues can become heated as diplomatic mission staff in New York defend deeply held positions. This has led to some entrenched positions and 'no-go' areas. Certain words have become 'code words' for a specific position on a sensitive issue, for example the words/terms 'family', 'marriage', 'parents', 'comprehensive sexuality education', 'gender' and 'key populations'. Member States will strive to remove 'code words' for positions they do not support and include 'code words' and phrases that support or explain their position or definition of a 'code word' (see annex 10 and footnote 2).

During negotiations delegations are invited to make suggestions on the text of each paragraph in the zero draft. The resulting compilation text can grow from 20 to 200 pages (these compilation texts are confidential, but frequently leak

out and are more widely available). Civil society activists use these compilation texts to lobby MS representatives to adopt one or other position on sensitive issues because civil society cannot provide inputs to the text.

When a 'nearly final text' is agreed, then representatives from Geneva and Ministries of Foreign Affairs from capitals, with greater technical expertise in health and human rights issues, come to New York to complete negotiations on the text for presentation to the High Level Meeting (HLM). By this time the text generally includes evidence of longstanding 'culture wars' around sensitive issues such as sexuality, family, sexuality education, HIV prevention etc. The HLM is the final negotiation on the text, which has been significantly cleaned-up by the co-facilitators, hopefully to include enough compromise language on which everyone can agree. During the HLM some negotiations and changes to text still occur and tensions still arise, but eventually consensus is reached. At the beginning of the HLM, the PD is adopted. MS representatives then welcome and make their final statements on the text. These are in the public domain and frequently indicate where MS still have reservations on the language in the adopted text (see annex 10).

There have been four PDs on HIV & AIDS adopted by MS in August 2001, June 2006, June 2011 and June 2016.[1] The texts of these four PDs and the debates surrounding their content form the focus of the textual analysis for this thesis. The PDs are not included in this text due to size constraints and are available at the web-links listed below for ease of reference.[2]

[1] The PD of 2001 used the abbreviation HIV/AIDS; subsequent PDS have used the abbreviation HIV & AIDS, in keeping with terminology used by UNAIDS. Unless referring specifically to the PD2001 or publications that use the term HIV/AIDS, the term HIV & AIDS is used throughout this document

[2] 2001: https://documents-dds-ny.un.org/doc/UNDOC/GEN/N01/434/84/PDF/N0143484.pdf?OpenElement
2006: http://data.unaids.org/pub/Report/2006/20060615_hlm_politicaldeclaration_ares60262_en.pdf
2011: http://www.unaids.org/en/media/unaids/contentassets/documents/document/2011/06/20110610_UN_A-RES-65-277_en.pdf
2016: http://www.unaids.org/sites/default/files/media_asset/2016-political-declaration-HIV-AIDS_en.pdf

1.2.2 HIV is a complex disease

The HIV epidemic is not simple to address, unlike some other diseases that can be managed through a combination of public health measures and strong public policy. The challenge is no longer the science; the public health measures needed to end the HIV epidemic as a public health threat by 2030 have been well defined and demonstrated to be effective. These include, combination HIV prevention and access to HIV testing and treatment (UNAIDS 2015c, 3). Rather, the challenge is the social inequities and human rights issues associated with the AIDS epidemic, which limit people's ability to prevent HIV infection and access testing and treatment. These challenges are discussed in chapters 3 and 4.

Some of these social inequities and human rights issues are highly sensitive and controversial. They involve sexual and reproductive health and rights (SRHR), gender and other inequalities, social stigma associated with AIDS, marginalization and criminalization of HIV transmission and behaviours that put people at risk of HIV infection. They have proven to be controversial both at national level, where health-care programmes are implemented, and in the global policy-making arena. Some of these issues were already a source of tension among MS at the UN before the advent of HIV.

Strong public policy and legislation is needed to protect the human rights of people living with HIV (PLHIV) and those groups regarded most at risk of HIV infection, in order to address the social inequities and human rights abuses driving increasing HIV infection rates. The Joint United Nations Programme on HIV & AIDS (UNAIDS) considers the groups most at risk – termed key population groups - to be gay men and other men who have sex with men, sex workers and their clients, transgender people, people who inject drugs, prisoners and other incarcerated people. These populations often suffer from punitive laws or stigmatizing policies (UNAIDS 2015d, 31). A multi-sectoral response is needed to bring the epidemic under control and address the complex set of issues that drive vulnerability to HIV infection.

1.2.3 The complex role of religion in the HIV response

The HIV response must draw on all sectors of society to develop effective national programmes. Civil society, including religious and faith-based organizations (FBOs), has been central to the response since the earliest days of the epidemic providing social, pastoral and health-care to people living with HIV. Faith communities and FBOs are essential to ending the AIDS epidemic as a public health threat. Significant proportions of national health-care services are provided through their large network of health-care facilities, especially in Africa, the epicentre of the epidemic (Blevins et al. 2017). Their networks of local faith communities provide essential social, psychological and home-based care.

Whilst some important synergies exist between religious approaches to HIV and other discourses operational in the HIV response (public health, human rights and gender equality, political leadership and national ownership) there are longstanding areas of disagreement on the sensitive issues of HIV prevention for key populations, human rights and gender equality, sexual and reproductive health and rights, sexual education and the family. Some of the tension and conflict concerns traditional religious definitions and interpretations of family, marriage, sexual relations and parenting, when these come into negotiations alongside the definitions and interpretations put forward by the public health and human rights community.

The religious discourse on HIV and SRHR is broad. Chapters 5 and 7 describe two ends of a broad spectrum of religious opinion on HIV, gender, sexual and reproductive health and human rights. There is much overlap and commonality between their positions and permeable boundaries between them. Labels are fraught with difficulty, some communities wish to be identified as ‘conservative’ and others consider that a criticism; similarly some would identify with the terms ‘liberal’ or ‘progressive’, but for others of a similar theological standpoint such terms are divisive. However, only a narrow spectrum of this very broad religious discourse is represented and put forward in the negotiations at the UN; reasons for this will be drawn out through this thesis. The main religious

discourse put forward in the negotiations on PD on HIV & AIDS at the UN is conservative, and whilst the Holy See is the primary conduit through which these interventions are put forward, the constituency is much broader than the Roman Catholic Church. Debates within the Roman Catholic Church itself on these issues are more nuanced and broad than their interventions on these issues at the UN would suggest. What unites a diverse set of conservative partners at the UN are contentious moral issues such as gender equality, sexuality education and abortion.

There is evidence of an ongoing polarization, and perhaps widening gap, between 'conservative' religious, traditional and cultural belief systems, and conservative politics on the one hand and 'liberal' approaches to HIV and SRHR based on public health, human rights and gender equality on the other. Together these threaten to undermine progress in a range of programmatic areas on health-care for women and the most marginalized (Goldberg 2017, National Catholic Reporter 2017).

1.2.4 Discourses in the HIV response.

In reviewing literature on the HIV response, seven main discourses are apparent:

- A public-health and biomedical discourse
- A human rights and gender equality discourse
- A traditional religio-cultural discourse
- A political leadership, national ownership and national sovereignty discourse
- A broader religious discourse
- A resourcing and financing discourse
- A discourse on the Agreement on trade related aspects of intellectual property rights (TRIPS)

Of these, all except the fifth; the broader religious discourse on HIV, are present in the text of all four PDs and the first five are the focus of this study. The latter two discourses are beyond the scope of this thesis and will not be considered.

1.3 Problem statement

There is tension and disagreement around the sensitive issues of HIV and SRHR at the UN in negotiations that seek to achieve consensus on the text of PDs on HIV & AIDS. The consequences of this are compromises in the text, which lead to limitations in national HIV responses and distorted funding flows. Religion is implicated as a source of this tension and conflict.

1.4 Statement of aim

This thesis aims to untangle the complex webs of meaning and power in AIDS policy-making and practice, in order to better understand the current tensions, polarization and conflict in the policy-setting arena and to identify possible strategies to overcome them that might strengthen religious engagement in both policy and practice in the HIV response.

1.5 Purpose of the research

The primary purpose of this research is to document and analyse five aspects:

The dominant discourses in the HIV response, as evident from both the literature and current practice, including: how the discourses have developed over time; the theories, assumptions and concepts that underpin the discourses; how these discourses operate at the UN in policy-making on HIV; and the main proponents of each discourse. This discussion is found in chapters 3 to 7.

How these discourses appear and interact in the final text of Political Declarations on HIV & AIDS of 2001, 2006, 2011 and 2016. Chapter 8 documents the influence of the discourses on the PDs on HIV & AIDS in order to identify what is present and what is missing from the negotiations and the text.

How a religious discourse appears in the Political Declarations on HIV & AIDS. Chapter 8 documents how the religious discourse influences the PDs and provides

specific examples of the influence of a traditional religious and cultural discourse on sensitive issues around HIV prevention. Chapter 9 explores in more depth the influence of a traditional religio-cultural discourse on issues relating to women, girls, young people and key populations in these texts. It includes a case study on the use of the word vulnerable, which is used as a proxy term for key populations.

The areas of tension and conflict in HIV & AIDS policy-making at the UN. Chapter 9 discusses areas of tension and conflict around women and girls, SRHR, young people and key populations in these texts. It also provides analysis of the problems facing the HIV response using some of the theories, concepts and assumptions underlying the discourses in order to identify possible sources of conflict and tension between the traditional religio-cultural discourse and the other dominant discourses in policy-making for the HIV response at the UN.

How religion operates in the broader HIV response. This is discussed in chapters 5 and 7. Understanding the role of religion in the broader HIV response makes it possible to identify areas of common ground, entry points and approaches to reduce the tension and conflict around HIV and SRHR at the UN.

A second purpose of the research is to develop an interdisciplinary understanding of the problem and from this, to generate recommendations on possible approaches to reaching agreement. These are included in chapter 10.

1.6 Research Questions

1. What are the current discourses operating at the UN in the policy-making space on HIV and SRHR?
2. How do the discourses appear and interact in the final text of the PDs on HIV & AIDS?
3. What topics and issues that appear in UNAIDS strategies are missing from or compromised in the negotiations and the final text of the PDs?

4. What are some possible explanations for these gaps? Is there a link between what is missing, and the influence of one or more of these discourses?
5. What are the elements of the broad religious discourse on, and approaches to, HIV that are active in the wider HIV response?
6. Are there ways in which a broader religious discourse including religious approaches that are supportive of public health, human rights and gender equality, might help bridge the gaps and bring new insights to the negotiating table?

1.7 Boundaries to the investigation

The textual analysis conducted for this research is limited to a detailed examination of the text of the four PDs on HIV & AIDS from 2001, 2006, 2011 and 2016, supported by reference to, but not detailed analysis of, other supporting UN documentation on AIDS.

The analysis of religious approaches to HIV and AIDS will be limited to the Christian faith tradition supported by some examples and references to engagement of other faiths in the HIV response. The scope of this study does not permit theological examination of more than one faith tradition. I recognize this is a significant limitation to the study and have attempted, where possible to refer to interfaith work, and provide examples from other faith traditions. Further research into the theology and teachings of faith traditions other than Christianity as they relate to HIV is needed. (Some of this has already been done for SRHR by the United Nations Population Fund (UNFPA) (UNFPA 2016)).

The study focuses primarily on Christian engagement in the global HIV response between 2010 and 2016, with a particular emphasis on the PDs of 2011 and 2016. It draws out more specifically the issues of, and discourses around gender equality, and the increased vulnerability of women and girls in sub-Saharan Africa. This is for two reasons. Firstly, rates of HIV infection in young women and adolescent girls in sub-Saharan Africa have been escalating rapidly for the last 10 years. Secondly, the discourse around gender and sexuality is one of the most

contentious issues at the nexus of HIV, public health, human rights and religion. This research addresses HIV prevention, human rights, young people, and key populations. Discussion of homosexuality and transgender in the context of HIV is less extensive in this study. The wider debate on religion and homosexuality is beyond the scope of this thesis. As there is little controversy in relation to HIV treatment in children, this topic is not addressed here. Detailed study of national responses to HIV & AIDS is beyond the scope of this thesis, but is also of critical importance to the global agenda and discussed briefly in Chapter 6.

1.8 Justification for selection of this topic

I selected this topic for several important reasons:

1.8.1 My Role

As Senior Adviser on Faith, and Faith-Based Organizations (FBOs) for UNAIDS I am responsible for catalysing and shaping UNAIDS relationships with FBOs and strengthening relationships between FBOs and other civil society partners. This role has an emphasis on encouraging constructive dialogue to address the complexities of faith, sexual and reproductive health, human rights, gender equality and HIV and, in this context, to drive forward constructive policy around sexuality, HIV, public health, culture and religion. This research is helping to fill some of the gaps in my own knowledge and understanding of these complex issues, as well as gaps in knowledge and understanding in the field in general.

Before this, through the 1980s and 1990s, I worked as a nurse with an FBO in Nepal, focusing on SRH and HIV. For the whole of my professional life therefore, I have found myself ‘standing in the gap’ and translating between different worldviews. This is not easy; nevertheless, in this polarized field, I have learned some essential lessons in navigation, advocacy, translation and negotiation. It remains a vital part of my own work to underline the importance of faith-based responses to HIV, and the common ground between human rights, evidence-informed public health practice and the theological concepts of justice and

dignity: a task in which I stand together, today, with a growing body of professional opinion. For example, Azza Karam et al, in the landmark series on faith-based healthcare published by the medical journal, *The Lancet*, remind us that an estimated 84 percent of the world's population is religiously affiliated (Karam et al. 2015). 'Faith….is a powerful force in the lives of individuals and communities worldwide'(Tomkins et al. 2015). Citing geographical coverage, influence, and infrastructure, *The Lancet* series argues that building on the extensive experience, strengths, and capacities of FBOs offers a unique opportunity to improve health outcomes.

1.8.2 Rationale for the selection of this topic as important to this work

This research is important because of the complex and interconnected role religion plays in the HIV response both nationally and internationally. It impacts the lives of individual people living with HIV in many countries, as well as having political influence on public policy at national and international levels. In addition, religious organizations are significant providers of health-care on HIV (UNAIDS 2013, 53, Olivier et al. 2015).

UNAIDS is clear that social, economic, structural and legal constraints have an impact on an individual's risk of acquiring HIV, their ability to access services and the impact of HIV infection on their lives (UNAIDS 2016d, 2015c). UNAIDS outlines a number of factors that increase the risk of HIV infection. Young people are at particular risk, for example, many young people lack adequate and accurate information on HIV and how to protect oneself from HIV infection, and lack adequate access to condoms (UNAIDS 2016d, 6-7). Male to male sex without a condom is a particular problem for young men who have sex with men (Grover 2010, 8). Intimate partner sexual violence is a particular problem for young women (UNAIDS 2016d, 7, Durevall and Lindskog 2015). For young people who inject drugs, 43 percent of countries with documented injecting drug use do not have needle-syringe programmes in place (UNAIDS 2016d, 6).

UNAIDS and the UN Special Rapporteur on the right to health have drawn attention to these increased risks (Grover 2010, 8, UNAIDS 2016d). In addition,

they highlight that criminalization of HIV transmission, sex work, drug possession for personal use and homosexuality has a negative impact on health and access to services (United Nations High Commissioner for Human Rights 2011, UNAIDS 2014, 203, Eba 2015, 255, UNAIDS 2016d, 16). Negative public opinion, stigma and discrimination towards people living with HIV (PLHIV) and key populations, especially from healthcare workers, are also critical factors which reduce access to HIV prevention and treatment services (UNAIDS 2012a, 78, 2016d, 16).

These are all areas where religion can have a powerful influence, in positive, negative or mixed ways, as this thesis will show. Religious leaders can influence attitudes and practices relating to stigma and discrimination and in many countries can also influence policy and legislation. Through their influence over faith-based health service providers in some countries, religious leaders can also influence health service delivery. Any insights from this research on ways, in which the positive influence of religion on HIV risk and impact can be maximized, will be an important contribution to global efforts to end the AIDS epidemic.

1.9 Research Design

This is an interdisciplinary research study, situated within the theoretical paradigm of Cultural Studies (CS). The research design is based on the methodological elements of Foucauldian Critical Discourse Analysis (CDA). The research design and methods are discussed in chapter 2, where these terms will be explained in full.

1.9.1 Research methods

This study utilizes the following approaches:

- A critical review of the relevant literature that underpins the various discourses on HIV & AIDS, which maps the main components of each discourse; explores the theories and academic disciplines that support it; and examines the assumptions and concepts within the discourse.

- A critical frame analysis, which consists of assessing the frequency with which key words appear in the text of the four PDs on HIV & AIDS from 2001, 2006, 2011 and 2016, as described by Mieke Verloo (Verloo 2016, 21).

- Close textual analysis of the four PDs on HIV & AIDS. This examines: how the discourses appear in, and influence the text; how they interact with each other in the text; the content of the PDs and the gaps in content.

- A reflective analysis, which crosses the boundaries of discourses, disciplines and theories. Using some of the steps of interdisciplinary research outlined by Allen Repko, this study analyses the problem from the perspective of the respective discourses; identifies conflicts between the discourses and their sources; identifies common ground among the discourses; creates interdisciplinary understanding; identifies potential areas of synergy and alternative models for engagement that exist within the discourses (Repko 2008).

These are the basis for producing conclusions and recommendations that will provide some new insights from the analysis of the broad religious discourse operating in the HIV response and put forward some suggestions on how the current tensions at the UN might be reduced in the future.

1.10 Findings and Analysis

This thesis argues that the four dominant discourses (listed 1-4 in section 1.2.4) are evident within the negotiations and text of the four PDs on HIV & AIDS (adopted in 2001, 2006, 2011 and 2016 respectively). Supporters of these discourses are also active in the broader context of policy and practice in HIV, health, development and humanitarian work. There is evidence of both collaboration and competition between supporters of the different discourses.

Findings from the critical frame mapping of terms and a close textual analysis of how those terms appear and are used in different ways in the text of the PDs are

discussed in Chapters 8 and 9. These demonstrate that the four discourses are evident in the text of the PDs and they change over time. These chapters will describe how the different discourses influence the text in different paragraphs and on different themes. Comparisons are drawn of the strength of the text in the PDs compared to that of the respective UNAIDS strategies, with particular reference to the UNAIDS 2016-2021 strategy and the 2016 PD. Areas of tension and conflict are apparent around HIV prevention, key populations, women, girls and young people.

Conclusions and recommendations are drawn from the analysis of how the different discourses influence the text and from a comparison of conflicts between the conceptual frameworks, which underpin the different discourses. Areas of common ground are identified from which a series of recommendations are made under three broad headings: i) Ask some new questions at the UN, ii) Explore some counter-intuitive processes, and iii) Apply some of this new understanding to the problem.

Chapter 2. Research Design & Methods

This interdisciplinary research is situated within the theoretical paradigm of Cultural Studies (CS). The research design is based on the methodological elements of Foucauldian Critical Discourse Analysis (CDA). The elements of this research design will be explained further in the following sections of this chapter.

2.1 Justification of the selection of an interdisciplinary approach

There are five main criteria commonly used to justify the selection of an interdisciplinary approach to research, namely that: ‘the problem is complex; important insights into the problem are offered by two or more disciplines; no single discipline has been able to address the problem comprehensively; the research problem is at the interfaces of disciplines; and the problem is an unresolved societal need or issue’ (National Academy of Sciences 2005, 30-35). These criteria all hold true for this research. The problem statement indicates that there is tension and conflict around the sensitive issues of HIV and SRHR at the UN, in negotiations which seek to achieve consensus on the text of PDs on HIV & AIDS. In this problem statement, disciplines underpinning healthcare, human rights and international policy are implicated as providing important insights into the problem.

The justification of the rationale for selecting this topic in section 1.8 has already outlined the complexity of the problem and cited literature from two relevant disciplines, public health and law. Each of these discourses is underpinned by disciplines that play a key role in the HIV response and contribute to both the problem and its solution. These will be explored in more depth in chapters 3-7. The problem, as the explanation in section 1.8 demonstrates, lies at the interface of these discourses and disciplines. The problem is currently unresolved. The UNAIDS 2016-2021 Strategy (hereafter Strategy2016) states that there is no magic bullet to end the AIDS epidemic, but that many disciplines and partners must work together in a coordinated response to achieve success (UNAIDS 2015c, 13). This is a critical societal issue, as AIDS

claimed the lives of 1.1 million people in 2015 when the 2016 PD was negotiated and 1.0 million in 2016 (UNAIDS 2016f) (UNAIDS 2017d).

2.2 Phases of the research process

Denzin and Lincoln outline four phases of the research process (Denzin and Lincoln 2005). Phase 1 locates the researcher as a multicultural subject; phase 2 explores the theoretical paradigms, concepts and perspectives; phase 3 outlines the strategies of inquiry and interpretive paradigms; and phase 4 sets outs the methods of data collection and analysis. For the analysis of this research however, a greater level of granularity is required than the phases articulated by Denzin and Lincoln. A fifth phase has therefore been added, which will follow the analytical steps of interdisciplinary research outlined by Allan Repko (Repko 2008).

2.2.1 Phase I ‘Locating oneself within the field’

My research is located in the fields of Practical Theology (PT) and Interdisciplinary Qualitative Research (QR) (Denzin and Lincoln 2005, 21). In the literature search, reflective practice and published articles submitted earlier towards this practical doctorate (Smith 2013, Smith 2016), I situated myself as a practical theologian, an interdisciplinary qualitative researcher, a public health practitioner and a UNAIDS staff member.

As a practical theologian my position is critical realist, believing that there is some external reality, namely a God, who can be known. As a public health qualitative researcher, I believe there is substantial social construction in evolving definitions of science, meaning, reality and religion. Recognizing that CS generally takes a social constructivist position, the research will take this into account. The critical realist approach is explained by Swinton and Mowat:

> Here it is useful to think in terms of a ‘continuum between naïve realism that accepts that truth can be fully accessed through human endeavour, that is, that theoretical concepts find direct correlates within the world,

> and a form of mediated or critical realism that accepts that reality can be known a little better through our constructions while at the same time recognizing that such constructions are always provisional and open to challenge (Swinton and Mowat 2006: 37).

2.2.2 Phase 2 Theoretical paradigms and perspectives

The theoretical paradigm for this research is cultural studies (CS). The work of Paula Treichler and Jill Olivier have set important benchmarks in the field of CS and HIV from which elements of the theoretical framework for this work are drawn (Treichler 1999, Olivier 2010). CS is itself defined as an interdisciplinary endeavour 'concerned with the analysis of cultural forms and activities in the context of the relations of power which condition their production, circulation, deployment and, of course, effects.' (Bennett 1998:60 cited in (Threadgold 2003: 1). Barker and Galasinski describe mainstream CS as a discipline which analyses ways in which power is reflected in the different representations of culture, through language, texts, signs and codes. They argue that CS has been limited to date, due to an overly narrow focus on written texts with insufficient attention to the interaction of language with lived experience. (Barker and Galasinski 2001: 21). This research attempts to respond to this challenge. It examines the influence of religion on the texts of international policy documents on HIV negotiated at the UN and situates this analysis within the broader discourse around religion in the HIV response as a whole.

Within the theoretical paradigm of CS there are two themes of particular importance to this research: mapping and complexity. Olivier expands on the theme of complexity:

> Cultural studies is based on a hermeneutic of complexity and instability, built on such concepts as a dialogic idea of culture where “the living utterance … (brushes) up against thousands of living dialogic threads”(Olivier 2010: 55).

This quotation provides a link between CS and the work of practical theologians, Swinton and Mowat, on complexity and the concept of the 'living human web' first articulated by practical theologian Bonnie Miller McLemore, who explores the metaphor of a living human web in light of the 'social inequities and injustices that perpetuate suffering' (Miller-McLemore 2008: 10). Swinton and Mowat explain how PT is about interpreting and unpacking the complexity of situations. They call this 'complexifying' a situation. By this they mean to discern its different components, to remember elements that have been forgotten or suppressed and to explore the historical context of a situation (Swinton and Mowat 2006: 13). In chapters 3-7 of this research some of the historical development of discourses active at the UN on HIV is documented, drawing out the different components and their history.

The literature review in chapter 4, of the issues which put young women at particular risk of HIV in sub-Saharan Africa, begins to explore something of this complex web. This interdisciplinary CS research at the intersection of religion, public health and HIV will hopefully unravel some of these threads, map connections, unpack complexity, deconstruct academic barricades and traditional demarcation lines to identify areas of new discourse, and build new synergies.

I use a model of CS similar to that developed by Jill Olivier. From her position of daily immersion in issues of faith and HIV in South Africa, Olivier takes as her case study the work of the African Religious Health Assets Mapping project (ARHAP), applying CS approaches to its work. She explores how current discourses around HIV and public health have affected the development of an international, interdisciplinary research community, and how their research has struggled to gain acceptance within the secular, public health community (Olivier 2010).

Taking up this concept of daily immersion, I conduct CS-based analysis at the intersection of HIV, sexuality, religion, public health, human rights and gender equality in public policy discourse on HIV. I focus on how a traditional discourse

on religion and culture plays out in the international policy-making arena at the UN on HIV and AIDS, drawing on the daily immersion through my role in UNAIDS.

In addition to CS as a theoretical paradigm for this research there are numerous theories and conceptual frameworks, which inform and shape the four dominant discourses operating at the UN on HIV and SRHR. Study of all them is beyond the scope of this study.

Four conceptual frameworks are of particular relevance to this thesis, as they are broad and operate across the disciplinary boundaries, are well established, are available in published form, and have been applied over a substantial period time. Three of these underpin Strategy2016; the Sustainable Development Goals (SDGs); the Gender mainstreaming conceptual framework for the Council of Europe (Council of Europe 1998) (henceforth CEGM framework); and the HIV and AIDS-related stigma and discrimination conceptual framework and implications for action (Parker and Aggleton 2003) (henceforth SDHIV framework). The fourth conceptual framework relevant to this study is the natural law theory and the teachings within the Catholic Church Catechism (Catholic Church 1997a, b) (henceforth NLCC framework) underpins the traditional religio-cultural discourse. All of these will be discussed below.

In chapter 10, the conceptual frameworks are subjected to interdisciplinary analysis, which includes a mapping exercise of their assumptions, definitions and concepts (see annex 1). This analysis aims to identify possible sources of controversy and conflict, potential synergies and common ground among the various discourses operating in the HIV response.

2.2.2.1 The Sustainable Development Goals (SDGs)

The SDGs were developed through a highly participatory process and adopted by the UNGA in 2015. These goals provide the broad framework for all health and development work for the next fifteen years; ‘They seek to realize the human rights of all and to achieve gender equality and the empowerment of all women and girls. They are integrated and indivisible and balance the three dimensions

of sustainable development: the economic, social and environmental' (General Assembly Resolution 2015, 1).

UNAIDS guiding principles for the HIV response are drawn from the SDGs and articulated in Strategy2016 (UNAIDS 2015c, 2):

- Aligned to national stakeholders' priorities;
- Based on the meaningful and measurable involvement of civil society, especially people living with HIV and populations most at risk of HIV infection;
- Based on human rights and gender equality;
- Based on the best available scientific evidence and technical knowledge
- Promoting comprehensive responses to AIDS that integrate prevention, treatment, care and support; and
- Based on the principle of non-discrimination.

The goals, targets and principles of Strategy2016 are clearly aligned to the SDGs (see chapter 3). Chapters 8 and 9, which analyse the 2016 PD, assess the extent to which PD2016 is shaped by this conceptual framework and reflects these goals, targets and principles.

2.2.2.2 Gender mainstreaming conceptual (CEGM) framework

The CEGM framework was developed for the Council of Europe in 1998, in order to provide a conceptual framework, recommendations and methodologies to integrate gender equality into public policy across Europe through an extensive process of research and analysis. The framework draws on gender theory and upholds the principles of human rights, democracy, economic independence, education and shared responsibility between men and women to build a more balanced society with men and women working together (Council of Europe 1998). It defines gender equality as follows:

> Gender equality means accepting and valuing equally the differences between women and men and the diverse roles they play in society.

> Gender equality includes the right to be different. This means taking into account the existing differences among women and men, which are related to class, political opinion, religion, ethnicity, race or sexual orientation. Gender equality means discussing how it is possible to go further, to change the structures in society which contribute to maintaining the unequal power relationships between women and men, and to reach a better balance in the various female and male values and priorities (Council of Europe 1998, 8).

The CEGM was selected for use in analysis in this research because it is a conceptual framework based on gender theory. It is practically applicable to the policy-making environment and has been developed by a group of technical experts, drawing on a wide range of academic sources and has been extensively applied to analyse gender in national policies across Europe (Council of Europe 1998). In this context it is being used as a proxy conceptual framework for gender theory.

2.2.2.3 The HIV and AIDS-related stigma and discrimination (SDHIV) framework

Parker and Aggleton describe the theories of stigma put forward by Erving Goffman in some detail, pointing out that early work to address stigma and discrimination in the HIV epidemic was broadly based on these theories. Goffman defines stigma as 'an attribute that is significantly discrediting', which 'in the eyes of society, serves to reduce the person who possesses it' (Goffman (1963) in (Parker and Aggleton 2003, 14). In this definition the concept of stigma is individualized. As a result, interventions to address stigma have been aimed at: 'increasing "tolerance" towards people with AIDS on the part of different segments of the general population'; at 'increasing empathy'; strengthening interaction between people living with HIV and others; and building 'coping skills' among PLHIV (Parker and Aggleton 2003, 16).

Parker and Aggleton argue that this approach is inadequate and refer to Michel Foucault's foundational work on the relationships between 'culture or

knowledge, power, and notions of difference' in understanding these issues (Parker and Aggleton 2003, 17). When the work of Goffman is put together with the work of Michel Foucault, an important shift, from a focus on the individual, to the structural becomes evident: 'their two bodies of work offer a compelling case for the role of culturally constituted stigmatization (i.e., the production of negatively valued difference) as central to the establishment and maintenance of the social order' (Parker and Aggleton 2003, 17).

In this context, they argue that stigma must be reframed as social processes of power, domination and control. This is because some groups stand to gain from the protection of power structures which legitimize inequalities within society, in which established structures of knowledge are used to highlight and support social difference, and where 'the so-called unnatural is necessary for the definition of normality' (Parker and Aggleton 2003, 17, 18). The SDHIV framework argues that 'definitions of deviance' are used by 'established regimes of knowledge and power' to maintain social order and control. The framework goes on to state that:

> While 'rule' is based on direct coercion, 'hegemony' is achieved via a complex interlocking of political, social and cultural forces which organize dominant meanings and values across the social field in order to legitimize the structures of social inequality, even to those who are the objects of domination (Parker and Aggleton 2003, 18).

The SDHIV conceptual framework was selected for use in the analysis in this research because it is an important theoretical framework that underpins a major shift in the framing of international policy on HIV stigma and discrimination. In addition, this framework also has implications for the broader HIV response beyond stigma and discrimination. It provides a theoretical framework for the major shift from a focus on the individual to a much stronger approach, which addresses the structural inequalities underlying vulnerability to HIV. Elements of this approach include strategies of increased community engagement, respect for human rights and gender equality, and an affirmation of community resistance.

The CEGM and SDHIV frameworks underpin the broad definition of public health, discussed in chapter 3. They support the conceptual framework of the SDGs for the HIV response, and are applicable to the Strategy2016 (UNAIDS 2015c); (Parker and Aggleton 2003, 22).

2.2.2.4 The natural law theory and teachings of the Catholic Church Catechism (NLCC)

The natural law theory and teachings of the Catholic Church on sexuality, marriage and the family recorded in the Catechism are selected for the analysis of this research because this is the theoretical framework which underpins the traditional religio-cultural discourse as put forward by the Holy See at the UN. This is evidenced by references to 'natural law' and Catholic teaching on sexuality, marriage and family in the academic literature, and the verbal interventions and written text provided by supporters of the traditional religio-cultural discourse in international policy-making arenas at the UN on HIV and SRHR (Catholic Church 1997a, b).

The Holy See considers 'natural law' to apply to everyone, regardless of whether they adhere to religious faith. Excerpts from the Catechism illustrate this point;

> The natural law, present in the heart of each man and established by reason, is universal in its precepts and its authority extends to all men. It expresses the dignity of the person and determines the basis for his fundamental rights and duties (Catholic Church 1997b, 1956).
>
> Application of the natural law varies greatly; it can demand reflection that takes account of various conditions of life according to places, times, and circumstances. Nevertheless, in the diversity of cultures, the natural law remains as a rule that binds men among themselves and imposes on them, beyond the inevitable differences, common principles (Catholic Church 1997b, 1957).

> The natural law is immutable and permanent throughout the variations of history; it subsists under the flux of ideas and customs and supports their progress. The rules that express it remain substantially valid. Even when it is rejected in its very principles, it cannot be destroyed or removed from the heart of man. It always rises again in the life of individuals and societies (Catholic Church 1997b, 1958).

2.2.3 Phase 3 Strategies of enquiry: Methodology

Foucauldian Critical Discourse Analysis (CDA) is suitable for this kind of research because it draws out connections between what is being said or written and the power politics of the culture within which the discourse sits. Michel Foucault's work, explores how knowledge, truth and power play out in speech and practice underpins current understandings of CDA (Mills 1997). CDA explores the ways in which discourses, not only explain culture and power relations within society, but also create, maintain and challenge power structures. Others have used this methodology to research issues of sexuality and HIV, in particular to explore the relationships between public discourse and power (Foucault 1990, Threadgold 2003, Silverman 2011, Olivier 2010, Treichler 1999, Fairclough 2009). There is increasing recognition of the importance of the intersection between these methods and calls for more work in this interface, for example:

> Fairclough is one of the few analysts, along with feminist discourse analysts like Thornborrow and Baxter, who have attempted to map out the connection between a close textual analysis and wider discursive and political structures. Critical Discourse Analysis, therefore, whilst constituting an engagement with what the notion of discourse means and how it informs the production of text, still needs to theorise more thoroughly the relation between texts and their contexts (Mills 1997: 140).

This research attempts to do just this, 'to map out the connection between a close textual analysis of the selected texts and the wider discursive and political structures' within which they sit.

2.2.4 Phase 4 Methods of Collecting Data

2.2.4.1 Step 1: Literature review

A broad literature review and scan of the field was conducted to identify the main discourses in the global HIV response. This review of the literature and programmatic action, and a close reading of the Political Declarations on HIV & AIDS, revealed seven main discourses.[3] They are each characterized by a series of key words, are supported by disciplines or schools of thought, and draw on specific assumptions and concepts. They are:

- A public-health/biomedical discourse
- A human rights/gender equality discourse
- A traditional religio-cultural discourse
- A political leadership, national ownership and national sovereignty discourse
- A broader religious discourse
- A resourcing and financing discourse
- A discourse on the Agreement on trade related aspects of intellectual property rights (TRIPS)

Of these, the first four discourses are dominant within the text of the four Political Declarations on HIV & AIDS and were all active in the negotiation process that led up to their adoption. These four discourses are also active in the broader context of policy and practice in HIV, health, development and humanitarian work.

[3] Sara Mills discusses common definitions of the term discourse and how more theoretical definitions have developed over the 1960's and describes discourse as follows:

> One of the most productive ways of thinking about discourse is not as a group of signs or a stretch of text, but as 'practices that systematically form the objects of which they speak' (Foucault, 1972, 49). In this sense, a discourse is something which produces something else (an utterance, a concept, an effect), rather than something which exists in and of itself and which can be analysed in isolation (Mills 1997, 15).

Discourses 6 and 7, on resources, financing and trade, also appear within the text of the PDs, but are not presented as a worldview. By this I mean that whilst they constitute an important discourse within the overall debate on HIV & AIDS and within the policy-making space they do not seek to influence the worldview of another discourse and so will not be discussed in detail in this thesis. They are also not part of the tension and conflict concerning the sensitive issues of HIV with respect to SRHR around which this research is focused.

Discourse number 5 is a much broader religious discourse than that which appears in negotiations at the UN and in the text of the PDs. It is also clearly apparent within the literature on HIV and AIDS and within the broader HIV response. UNAIDS partnership work with FBOs over the last two decades reflects and has fostered this discourse.

Chapters 3-7 critically review the relevant literature of each of the five discourses. Each chapter can be considered as a 'memorandum' on the discourse, which attempts to map the main components of that discourse, explore some of the theories and academic disciplines which support it, and examine the assumptions and concepts within it.

2.2.4.2 Step 2: Frame mapping

Using the literature review and key words identified for the four discourses which appear in the PDs on HIV & AIDS (from 2001, 2006, 2011 and 2016), a critical frame analysis was conducted. Verloo et al define a policy frame as 'an organising principle that transforms fragmentary or incidental information into a structured and meaningful policy problem, in which a solution is implicitly or explicitly enclosed' (Verloo 2016, 20). This relates to the way a discourse can be used within a policy document to shape the policy problem. A frame mapping consists of assessing the frequency with which key words appear in a text and helps in providing the basic data for a comparative analysis of the texts, but alone is too simplistic to analyse complexity (Verloo 2016, 21).

To conduct the frame mapping, key words corresponding to each discourse were clustered into groups and a spreadsheet was constructed to record the frequency with which each term appears in the PDs and present them graphically (see annex 2.2). These graphs show changes in the way terms are used over time; some terms appear frequently, others, frequently used in the broader literature review and the HIV response, are missing altogether from the text of the PDs.

Re-reading the texts in light of this mapping revealed that some words were being used as a proxy or a substitute for others. From my daily immersion in the field, I knew that some words are problematic for some constituencies at the UN. Here was solid evidence that some terms were being avoided, and that this avoidance changed the way other terms were used in the text. This insight prompted the next phase of data collection and analysis.

2.2.4.3 Step 3: Close textual reading

Close textual reading of the four PDs on HIV & AIDS was conducted. A colour was assigned to each of the discourses: blue for public health/biomedical; green for human rights and gender equality; pink for the traditional religio-cultural; orange for political leadership, yellow for financing; red for trade. The text was highlighted phrase by phrase, word by word in each colour in each of the four PDs.

The close textual analyses of the four PDs on HIV & AIDS examined how the discourses appear in and influence the text, how they interact with each other in the text, and exposed some of the missing pieces or gaps. Through the colour coding, it was possible to lift all the text reflective of a particular discourse to read it as a composite whole. It was also possible to see how particular words (for example the word vulnerability) were being used as a substitute for others, and how this changed over time. It was clear that some words reverted to their original usage or meaning once their use as a substitute ended.

Patterns and trends were clearly apparent through the colour-coding exercise, which were not evident through a simple reading of the text. In one paragraph

you can see sentences and phrases in alternating colours. On closer reading, when a paragraph flip-flops back and forth between discourses (and colours) there was evidence of tension between the discourses. Other paragraphs demonstrated one or more discourses working together in support of a common goal (see annex 2.1 for examples of the colour coding).

2.2.4.4 Step 4: Tracking changes from 'zero draft' to final text

Using 'zero drafts' of the texts,[4] some of the paragraphs where tension was apparent were tracked to see how the text changed from the zero draft to the final version. Compilation texts, produced by the UN during the process of the negotiations, indicate which MS requested changes of wording on which paragraphs. These are confidential to the negotiations, and therefore not available to this study. However, final statements made by MS after adoption of the PD are in the public domain and these frequently indicate which MS had concerns about which paragraphs and why. This provides insights into how MS are using the different discourses in the negotiations.

2.2.4.5 Step 5: Analysis of selected paragraphs using template of 'sensitizing questions'

Selected paragraphs, identified through the previous steps as containing sensitive issues, or paragraphs around which there was tension and conflict, were interrogated using a template designed by Verloo et al. The template contains a series of 'sensitizing questions', to draw out how the text frames the diagnosis of the problem, attribution of causality, prognosis and call for action. The template also identifies who has 'voice' in making those decisions, which is important in discerning where the power lies (Verloo 2016, 24).

2.2.5 Phase 5 Analysis

[4] The 'zero drafts' are prepared by the two government 'facilitators' for the negotiations in collaboration with the UN agency (in this case UNAIDS) responsible for the technical area. The zero drafts generally follow closely the strategy documents of the technical agencies concerned.

For the analysis of this data, five steps of interdisciplinary analysis outlined by Allan Repko were used. The first analyses the problem from the perspective of each of the disciplines (Repko 2008, 217). Chapters 3-7 outline each of the discourses and provide disciplinary perspectives on the factors which drive the HIV epidemic. Potential solutions, from the perspective of these disciplines (which underpin the discourses) are also discussed in these chapters.

The next step is to identify the conflicts between the disciplinary insights and locate where these conflicts originate. The conflicts often originate in different definitions, assumptions and concepts that underpin the discipline (Repko 2008, 248). For example, conflicts can arise when the same term appears in two different disciplines, but is defined in very different ways. A mapping of the definitions, assumptions and concepts of the disciplinary theories underpinning the public health discourse, human rights and gender discourse and the traditional religio-cultural discourse was conducted and is included in annex 1. Chapter 9 contains the analysis of where the conflicts may be located based on this mapping.

Once the conflicts and their sources have been identified, possible areas of synergy or common ground are sought (Repko 2008, 271). For instance, promising sources of common ground or synergy occur when concepts have similar meanings in two different disciplines, but are identified by different terms. Repko notes that 'Creating common ground involves bringing out potential commonalities underlying the conflicting disciplinary and theory-based insights so that these can be reconciled and ultimately integrated' (Repko 2008, 272).

Following identification of common ground, insights from the different theories can be integrated to demonstrate how, together, they can provide a better explanation than any one theory can provide alone (Repko 2008, 302).

Finally, this newly identified interdisciplinary understanding can be expressed in a way that can be tried and tested. Repko identifies six possible ways in which these ideas can be presented, of which I have selected three: to present a *model*

which could be used to apply the new learning to a specific situation; a *new question* may be proposed; a *new plan*, policy or *way forward* may be proposed (Repko 2008, 311). Each of these analytical steps has been followed, drawing on the first broad sweep of the literature and practice, and on the close reading and analysis of the text of the four political declarations on HIV & AIDS. The discussion of this analysis can be found in chapters 8 and 9.

Conclusions and recommendations are drawn from this analysis and attempt to provide some new insights, some of which are located within the broader religious discourse operating in the HIV response, but currently excluded from the negotiations on HIV policy at the UN. Some suggestions are provided from this analysis on how the current tensions at the UN might be reduced in the future. These can be found in chapter 10.

2.3 Research Ethics

This research was conducted using documents in the public domain. I did not conduct individual interviews with human subjects or report on private conversations (Marvasti 2004: 136).

Part A: Articulating and documenting the discourses in the literature and practice of the HIV response

Interdisciplinary research seeks to work across multiple disciplines, each of which commonly has its own very substantial history and literature base. Part A responds to the first purpose statement of this research set out in Chapter 1, to document and analyse the dominant discourses in the HIV response as evident in both the literature and current practice on HIV, including to explore: how the discourses are framed in the literature and strategic documentation of the technical or specialist organizations; the theories, assumptions and concepts that underpin the discourses; how the discourses have developed over time, including some of the areas of debate; how these discourses operate at the UN in policy-making on HIV; and who the main proponents and supporters of each discourse are. These, of necessity will be limited reviews of a very broad literature and practice and will therefore highlight issues of particular relevance to this research.

I recognize that this review is coloured by my position as senior adviser on faith and religion within UNAIDS, by the work that I have led for the last ten years within UNAIDS and the partners with whom we have worked, and by the issues that together, we have sought to advance in this complex field of HIV and public policy on AIDS.

Part A responds to research questions one and five of this thesis:

- What are the current discourses operating at the UN in the policy-making space on HIV and SRHR? (Chapters 3,4,5 and 6)
- What are the elements of the broad religious discourse on, and approaches to HIV that are active in the wider HIV response? (Chapter 7).

Part A consists of five chapters, one for each of the discourses: Chapter 3. Public health and biomedical; Chapter 4. Human rights, gender equality and community engagement; Chapter 5. Traditional religio-cultural; Chapter 6. Political leadership and national sovereignty; Chapter 7. Broader religious.

Each chapter will be structured in the same way, to form a series of discourse ‘memoranda’ with similar sub-headings. Additional information supporting the discourses is provided in annexes 3,4,5,6 & 7.

- Introduction, key words, research questions
- Framing the discourse from literature and practice of the HIV response
- Conceptual frameworks
- Development and debates
- Supporters and strategies
- Conclusions

This review builds on several pieces of work previously submitted for this practical doctorate or published by the author. Previous work has described the AIDS epidemic as ‘a multi-sectoral challenge, spanning the areas of public health, politics, social justice, human rights, gender and sexuality, religion and theology’ and has summarized the early literature and discourse in each of these areas (Smith 2013, UNAIDS 2016c, 2015b). Other authors have provided similar overviews of the literature. The texts listed below constitute some of the most comprehensive reviews of current literature on the subject of religion and the HIV response. Four publications have been selected as central texts for the review in chapter 7; i) the CHART database, ii) the accompanying book *Religion and HIV and Aids: Charting the Terrain*, which provides scholarly analysis of literature in this database in the context of community responses, iii) the *Lancet* special edition on faith and health care, which is based on an extensive review of current literature, and iv) *Passion and Compassion* by Manoj Kurian, which documents the history, literature and the churches’ response to HIV. (Olivier et al. 2006, Olivier 2010, Haddad 2011, Tomkins et al. 2015, Kurian 2016). Chapters within this section draw on these publications.

Given the limits of this thesis, previous material will not be repeated in full, rather referenced and augmented, including information from additional publications, particularly literature since 2011. These framing chapters will be

the reference point for later chapters in the thesis which will examine the extent to which the policy frame of Strategy 2016) is reflected in the 2016 PD.

It is important to distinguish, at the outset, the difference between a policy frame and a discourse (which is much broader). Chapter 2 provides a brief description of the term discourse. Within Critical Discourse Analysis (CDA), discourse is defined by Norman Fairclough as:

> Language used in speech and writing- as a form of 'social practice'. Describing discourse as social practice implies a dialectical relationship between a particular discursive event and the situation(s), institution(s) and social structure(s), which frame it: The discursive event is shaped by them, but it also shapes them. That is, discourse is socially constitutive as well as socially conditioned- it constitutes situations, objects of knowledge, and the social identities of and relationships between people and groups of people. It is constitutive both in the sense that it helps to sustain and reproduce the social status quo, and in the sense that it contributes to transforming it. Since discourse is so socially consequential, it gives rise to important issues of power. Discursive practices may have major ideological effects- that is, they can help produce and reproduce unequal power relations between (for instance) social classes, women and men, and ethnic/cultural majorities and minorities through the ways in which they represent things and position people (Fairclough and Wodak 1997, 258).

A policy frame is defined by Mieke Verloo as follows:

> [A] policy frame is an organising principle that transforms fragmentary or incidental information into a structured and meaningful policy problem, in which a solution is implicitly or explicitly enclosed (Verloo 2016, 20).

These chapters attempt to describe each broad discourse. Where there are specific policy documents which contain a policy frame in line with Verloo’s definition, this will be indicated.

Chapter 3. The public health and biomedical discourse

3.1 Introduction, key words and questions.

This chapter discusses the current discourse on public health and the HIV response, drawn largely from Strategy2016 (UNAIDS 2015c). Strategies produced by UNAIDS are based on systematic literature reviews and current epidemiological data and are developed through a widely consultative process with MS, the 11 UN cosponsoring agencies and civil society. They build on lessons learned from the literature and thirty years of experience in the HIV response. They are drafted by the UNAIDS Secretariat and negotiated and agreed by the Programme Coordinating Board (PCB).

This will be augmented by reference to the suite of documents prepared in advance of the High-Level Meeting (HLM) on AIDS, which took place in New York in June 2016. The documentation prepared in advance of the meeting was developed from systematic reviews of current literature and best evidence available, and included : Strategy2016; the World Health Organization (WHO) *Global Health Sector Strategy on HIV 2016-2021* adopted by the World Health Assembly in May 2016 (WHO 2016b); *On the fast track to ending the AIDS epidemic. Report of the Secretary-General* (Secretary-General 2016); and the Lancet Commission Report *Defeating AIDS—advancing global health* (Piot et al. 2015). For this reason, Strategy2016 and the suite of documents prepared in advance of this meeting are used as the basis for this literature review and framing of the discourse.

The words and phrases associated with the public health and biomedical discourse on AIDS, identified through the literature review and close reading of the PDs include:

Evidence-based; target; key population; population at higher risk; men who have sex with men; sex worker; people who inject drugs; location; pandemic; epidemic; epidemiology; comprehensive; prevention; treatment; harm reduction; condoms; commodities; effective; integration; sexual and

reproductive; health services; maternal and child health; tuberculosis (TB); disaggregated; data; incidence; prevalence; monitoring and evaluation; goals and targets; strategies; research; scientific knowledge; public health; sexuality education; drivers; transgender; health systems; diagnosis; adherence; treatment regimens; prophylaxis; drug resistance; crisis; urgent.

As explained in section 2.2. a frame mapping was conducted using the words from this list that appear in the PDs. Annex 2.2 provides a graphical representation of the number of times selected terms indicative of this discourse appear in the text of each PD.

The chapter will seek to answer the following questions:

- What are the main elements of the public health, biomedical discourse, as found in the technical strategies on HIV & AIDS?
- What are the goals and targets, strategic directions and actions proposed by Strategy2016?
- What are the underlying conceptual frameworks informing the development of Strategy2016?
- What are some of the debates and tensions within the public health and biomedical community relevant to this thesis?
- Who are the supporters of this discourse in policy negotiations at the UN and what are their strategies to position this as the dominant discourse?

3.2 Framing the discourse from the literature and practice of the HIV response.

The lead technical agencies, UNAIDS and WHO, put forward policy frames in their technical strategies on HIV and AIDS. They frame the pandemic primarily as a public health issue, and articulate a broad definition of public health, including not only biomedical approaches to the pandemic, but also a clear articulation of the human rights and gender equality issues that need to be addressed as part of that broad public health response to HIV (WHO 2016b,

UNAIDS 2015c). They are intended to drive specific policy for effective HIV programming.

This is important because this is different from the public health approach historically and currently adopted for other diseases, which tends to focus on the more scientific, technical and biomedical approaches to disease control. The wider discourse of public health acknowledges the importance of what are called the 'social determinants of health', including human rights, gender equality and community participation etc. (Marmot et al. 2008). These elements are defined by the WHO Commission on the Social Determinants of Health (WHO 2008). In general, however, they take second place to a technical and biomedical approach. The UNAIDS and WHO strategies on HIV also lay the foundations for other discourses in the HIV response, namely the discourses of human rights and gender equality, community engagement and political leadership.

One central element of this study is to explore the extent to which the policy frames of the technical agencies are reflected in the policy frame that is finally included in the PDs themselves. What is retained and what is lost at the end of a political negotiation process where other powerful discourses, such as the national sovereignty and traditional religio-cultural discourse are at play? Analysis in chapter 8 will reflect on the extent to which the PDs include this framing and reflect the strategic directions put forward.

3.2.1 Main elements of the public health, biomedical frame as found in the technical strategies on HIV & AIDS

At the centre of the UNAIDS strategic approach are commitments to partnership, inclusiveness, and human rights. Whilst a commitment to high quality scientific and technical responses is critical, this does not take priority over inclusion, participation and human rights. This broad approach to, and framing of, public health is also central to the WHO health sector strategy and all the elements of this approach as set out by the two strategies are included in the report of the SGto the UNGA(WHO 2016b, Secretary-General 2016). This is important to note,

because such a broad definition of public health is not always as apparent in responses to other diseases.

The list of principles (UNAIDS 2015c, 2) and the quotation from the Executive Director of UNAIDS, which opens Strategy2016 both illustrate the broad definition of public health:

- Aligned to national stakeholders' priorities;
- Based on the meaningful and measurable involvement of civil society, especially people living with HIV and populations most at risk of HIV infection;
- Based on human rights and gender equality;
- Based on the best available scientific evidence and technical knowledge;
- Promoting comprehensive responses to AIDS that integrate prevention, treatment, care and support; and
- Based on the principle of non-discrimination

> The AIDS movement, led by people living with and affected by HIV, continues to inspire the world and offer a model for a people-centred, rights-based approach to global health and social transformation. Michel Sidibé (UNAIDS 2015c, 3).

This framing of the epidemic and response, which puts the leadership and participation of PLHIV front and centre, as well as people most at risk of and affected by the epidemic and a wide range of partners, has been characteristic of UNHIV response since its creation in 1996. This is important because the HIV response is different to other disease responses in this regard. The WHO Global Health Sector Strategy on HIV is also clear that it takes as its foundation this broad definition of public health:

> The strategy is rooted in a public health approach that is concerned with preventing disease, promoting health, and prolonging life among the population as a whole. It aims to ensure the widest possible access to high-quality services at the population level, based on simplified and

> standardized interventions and services that can readily be taken to scale, including in resource limited settings. A public health approach aims to achieve health equity and promote gender equality, to engage communities and to leverage public and private sectors in the response. It promotes the principle of health in all policies through, where necessary, legal, regulatory and policy reforms. It aims to strengthen integration and linkages between HIV and other services, improving both impact and efficiency (WHO 2016b, 21).

This recognition by both organizations, that a narrow biomedical and technical approach to public health is inadequate to address this complex epidemic is central to both the success of the response to date and to some of the tensions and conflicts that hinder progress and which this thesis will explore.

3.2.1.1 Goals, targets and result areas

Both the UNAIDS and WHO strategies build on the goals and targets of the Sustainable Development Agenda adopted by the General Assembly of Member States at the UN in 2015 (General Assembly Resolution 2015), commonly known as the SDGs. The SDGs also provide an underlying conceptual framework for the two strategies as summarized in the WHO strategy:

> The Sustainable Development Goals provide an ambitious and far-reaching development agenda for the period 2016–2030. Health is a major goal in this post-2015 agenda, reflecting its central role in alleviating poverty and facilitating development. The health-related Sustainable Development Goal (Goal 3) addresses a range of health challenges critical for development, notably target 3.3 on communicable diseases, which includes ending the AIDS epidemic. Efforts to end AIDS will also impact on other health targets, including on reducing maternal mortality (target 3.1), preventing deaths of new-borns and children under the age of 5 years (target 3.2), reducing mortality from non-communicable diseases and promoting mental health (target 3.4), preventing and treating substance use disorders (target 3.5), sexual and reproductive health

> (target 3.7), achieving universal health coverage (target 3.8), access to affordable medicines and vaccines (target 3.b) and health financing and health workforce (target 3.c). In addition to its impact on Goal 3, ending the AIDS epidemic will contribute to ending poverty (Goal 1), ending hunger (Goal 2), achieving gender equality and empowering women and girls (Goal 5), reducing inequality in access to services and commodities (Goal 10), promoting inclusive societies that promote non-discrimination (Goal 16), and financing and capacity building for implementation (Goal 17) (WHO 2016b, 19).

Whilst SDG 3 is clearly a public-health goal, the goals and targets of both the UNAIDS and WHO strategies are spread across five of the SDGs, demonstrating that the AIDS pandemic and response is much broader than health alone. The specific goals and targets, to be achieved by 2020 in order to end AIDS as a public health threat by 2030 as set out in both strategies, are listed in annex 3.

Strategy2016 outlines action in three strategic directions to achieve these goals and targets. The first strategic direction is HIV prevention, the second is treatment, care and support, and the third is human rights and gender equality for the HIV response. I have intentionally included several long quotations from the UNAIDS and WHO technical strategies on HIV at the beginning of this chapter, as it is important to describe clearly the public health framing as used by WHO and UNAIDS, and to explain how it is articulated in these technical documents, in order that later analysis can draw out where the 2016 PD differs from the policy frame put forward in the two technical strategies. In line with this framing, Strategy2016 puts forward eight result areas clustered under five of the SDGs (UNAIDS 2015c, 10, 11) (see annex 3). These SDGs and result areas are also the starting point for the human rights and gender equality policy frame laid out in these strategies, which will be discussed further in chapter 4.

3.2.1.2 Technical and biomedical components

Within this broader definition of public health, there are very strong technical and biomedical components. The first of these components is that the HIV

response must be based on solid data about the scale, scope and impact of the epidemic. This data must be accurate and broken down (disaggregated) according to the population groups and locations where the epidemic hits hardest. Unless one is clear about who is getting infected, where and why, then attempts to control the epidemic will be ineffective.

The WHO Global Health Sector Strategy identifies three areas where countries can take action to strengthen the quality of this information to shape their programmes accordingly; first, to build a comprehensive strategic information system in line with established WHO and UNAIDS guidelines on data collection methodologies and indicators; second, to increase data disaggregation down to local levels geographically, and by age, sex and population so that services can be targeted where they are most needed; and third, to link strategic information on HIV to health information systems for other diseases to create integrated information platforms. This is important because people living with HIV show up with other diseases in different parts of the health system, and the system must be able to communicate across the sectors to control the epidemic effectively (WHO 2016b, 30).

There is significant tension around strengthening the collection and disaggregation of data on key population groups, which is discussed again in chapters 9 and 10.

Strategy2016 and the UNAIDS Prevention Gap Report set out the progress to date and the numbers of people newly infected, living with and on treatment for HIV as follows:

> In 15 years, the annual number of people newly infected by HIV has dropped from 3.1 million to 2.0 million. Globally between 2000 and 2014, the number of children acquiring HIV fell by 58 percent to 220 000 per year (UNAIDS 2015c, 13).

> Of the two million new HIV infections, approximately half took place in Sub-Saharan Africa, where women and girls are at particular risk of infection (UNAIDS 2015c, 14).

One of the greatest areas of success has been in providing antiretroviral treatment (ART) to people living with HIV. In 2015 there were estimated to be 17.0 million people accessing ART. This is the first time that a public health target (15 million PLHIV accessing treatment by 2015) has been achieved nine-months early and this success has reduced deaths from HIV by 26 percent since 2010. When PD2016 was adopted, of the 36.6 million people estimated to be living with HIV globally, approximately 60 percent knew their HIV status, 46 percent were taking ART and 38 percent had achieved viral suppression (UNAIDS 2016d, 18).[5] This means ART has reduced the HIV virus in their body fluids to an undetectable level, and they are not infectious to their sexual partner. This is of huge importance in saving lives and in HIV prevention. The provision of ART is generally a non-controversial area and potentially an entry point for building common ground between the public health discourse and the traditional religio-cultural discourse.

There has been significant progress in reducing new HIV infections in infants as a result of efforts to establish an AIDS-free generation through an initiative called '*Countdown to Zero. Global Plan towards the Elimination of New HIV Infections Among Children by 2015 And Keeping Their Mothers Alive'* (UNAIDS 2011b). Through this initiative there has been a greater effort to provide mothers with testing for HIV. If they test HIV positive, they are provided with ART to prevent

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[5] Updated Global HIV data for 2017 can be found on the UNAIDS website, but was not available at the time PD2016 was adopted: **Global HIV statistics** 20.9 million people were accessing antiretroviral therapy in June 2017. 36.7 million [30.8 million–42.9 million] people globally were living with HIV in 2016. 1.8 million [1.6 million–2.1 million] people became newly infected with HIV in 2016. 1 million [830 000–1.2 million] people died from AIDS-related illnesses in 2016. 76.1 million [65.2 million–88.0 million] people have become infected with HIV since the start of the epidemic. 35.0 million [28.9 million–41.5 million] people have died from AIDS-related illnesses since the start of the epidemic. **People living with HIV** In 2016, there were 36.7 million [30.8 million–42.9 million] people living with HIV. 34.5 million [28.8 million–40.2 million] adults 17.8 million [15.4 million–20.3 million] women (15+ years) 2.1 million [1.7 million–2.6 million] children (<15 years) (UNAIDS 2017c).

the HIV virus from being transmitted to their infant, and to protect their own health for the rest of their lifetime. This is important, as healthy mothers are central to raising healthy children. The programme averted 1.6 million HIV infections among children between 2000 and 2015 (UNAIDS 2015c, 24).

The HIV response has been less successful in scaling up access to ART for children already infected with HIV. In 2015 access was 'appallingly low, with coverage ranging from 54 percent in Latin America to 15 percent in the Middle East and North Africa' (UNAIDS 2015c, 14). In addition, the rates of new HIV infections among young women had not reduced, nor had unintended pregnancies. These serious concerns have led to the launch of a new initiative to address the challenge called the '*Start Free, Stay Free, AIDS Free Initiative*'(UNAIDS 2016e). Religious and faith-based organizations have been at the forefront of advocacy to launch and implement both initiatives, but not without some controversy, around issues of HIV prevention in adolescent and young women. Some of the underlying issues behind these gaps will be expanded further in chapter 4 on human rights and gender equality.

There are other groups among whom HIV infection rates continue to rise:

> Key populations—including sex workers, people who inject drugs, transgender people, prisoners and gay men and other men who have sex with men—remain at much higher risk of HIV infection. Recent studies suggest that people who inject drugs are 24 times more likely to acquire HIV than adults in the general population, sex workers are 10 times more likely to acquire HIV and gay men and other men who have sex with men are 24 times more likely to acquire HIV. In addition, transgender people are 49 times more likely to be living with HIV and prisoners are five times more likely to be living with HIV than adults in the general population (UNAIDS 2016d, 7).

These data show that the HIV epidemic is still a formidable challenge, and that the people groups among whom the epidemic is at its most fierce are some of the most marginalized in society. Working with these groups has not been easy

for many faith and religious communities, because certain public health approaches to address rising HIV infection rates among these groups do not resonate well with religious approaches to these same issues. These areas are where some of the conflicts and tensions arise that this thesis will explore.

3.2.1.3 Strategic directions and actions proposed.

Strategy2016 proposes two strategic directions to achieve the goals and targets and provides specific information on the technical elements and actions needed to successfully address national epidemics. These are outlined in detail in annex 3.

3.2.1.3.1 UNAIDS Strategic direction one: HIV prevention- a technical package

In their technical strategies, WHO and UNAIDS advocate the implementation of a core package of combination HIV prevention (WHO 2016b, 34, UNAIDS 2016d, 7) and treatment interventions (WHO 2016b, 38, UNAIDS 2016a) to address some of the specific vulnerabilities highlighted above and end the AIDS epidemic as a public health threat by 2030. These interventions are based on scientific evidence of what works to reduce new HIV infections. This technical HIV prevention package is outlined in detail in annex 3. The prevention framing is particularly important to this thesis as there is conflict and tension between some of the elements of the carefully defined combination HIV prevention strategy and a traditional religio-cultural discourse.

3.2.1.3.2 UNAIDS Strategic direction two: treatment care and support- the HIV treatment technical package

Scaling up ART provision saves the lives of people living with HIV; it is also a central part of HIV prevention. This thesis and framing section do not focus on treatment, as it is not a source of tension with the traditional religio-cultural discourse, rather treatment is a potential entry point for collaboration. The main elements of a successful HIV treatment technical package as outlined in Strategy2016 are outlined in annex 3.

3.3 Conceptual Frameworks

There are four conceptual frameworks of relevance to this thesis, three of which underpin Strategy2016, and which have been explained in chapter 2, section 2.2. Chapters 9 and 10 will revisit these conceptual frameworks to analyse potential areas of conflict and synergy.

3.4 Development and debates within the public health and biomedical community

One area of tension is between a broad definition of public health as taken by the AIDS community and a narrower biomedical approach taken by some of the other disease control programmes.

Historically there has been considerable tension between the biomedical and broader rights-based public health approaches to the management of health and illness. Current tensions between the biomedical and broader definitions of public health is outlined in more detail in annex 3. Its relevance to the secularist discourse is discussed in chapter 6, because biomedicine is often closely associated with hard secularism.

AIDS has been an important pathfinder in this regard, and similar broad approaches to public health have been taken up by other programmes such as TB and mental health. Peter Piot et al describe a conceptual model for AIDS and a global health approach which build on the broad conceptual frameworks that underpin the HIV response. It includes leadership and engagement of affected communities in decision-making bodies; fostering human rights and social justice activism; pursuing smart integration, operational convergence and system strengthening; building and reinforcing multi-stakeholder collaboration across the sectors by strengthening accountability through joined-up mechanisms and better data on shared determinants and investing in rollout innovation and implementation research (Piot et al. 2015, 33-35).

The important point for this thesis is that in the current HIV response, historical tensions between a broad definition of public health and a narrower biomedical approach to disease have been replaced by tensions within the HIV-related public health discourse itself. That is, by tensions between the broad public health approach to AIDS, as framed by UNAIDS and WHO technical strategies, and the narrower biomedical and more individualistic approach, which has been taken up by more traditional countries and conservative religious communities. This is a feature of the national sovereignty discourse. This more traditional approach, heavily informed by biomedical thinking, does not seek to engage with communities at a deeper level. It avoids controversial and difficult issues around sexual orientation, sex work, drug use, sexual violence and power dynamics in sexual relationships. It does not address issues of human rights and the marginalization, stigma and discrimination embedded in communities. Such a public health approach is certainly easier to implement and may be politically and religiously palatable in some countries, but in the case of AIDS, it does not address the problem effectively. It is this debate which this thesis will address.

3.5 Supporters and Strategies

This section will discuss the supporters of the public health, biomedical discourse in the policy-making space at the UN, and the strategies and methods for providing this support.

This discourse and the policy frame described in this chapter and set out in the UNAIDS and WHO strategies has been actively supported by MS of the Western European and Others Group (WEOG) group, Brazil, the United States of America (USA), Thailand, South Africa and others from Latin America in negotiations at the UN. There are some elements of the framing that these countries will support wholeheartedly, and other areas where they have some reservations based on national political constraints. These and other supportive countries generally work together in the negotiations to support the broad framing of public health as put forward in the UNAIDS and WHO strategies as a whole and will actively speak up in negotiations and add wording to the PD drafts in support of this framing. Positions taken in the negotiations (which are

confidential) are evident from public statements made in plenary sessions and at the adoption of the text.

UNAIDS, WHO and other technical agencies also support this framing in the run-up to the negotiations. One very specific way to do this is to develop the UNAIDS and WHO strategies in advance of the negotiations at the UN and to engage MS through their respective governing bodies (who adopt the strategies) in their design and adoption. Staff from the UNAIDS Secretariat work together with the two country co-facilitators of the negotiations at the UN to develop the first draft of the PD based on the framing laid out in the UNAIDS and WHO strategies.

In advance of the HLM on HIV & AIDS, a series of technical briefings are held by the co-facilitators, UNAIDS secretariat and cosponsoring agencies. These briefings serve to provide the technical information and data, which are the underlying rationale for the goals, targets, strategic approaches and actions proposed in Strategy2016 and zero draft PD, to government negotiators in New York. During the question and answer sessions at these briefings the political, religious and cultural reservations are frequently expressed by MS, largely from the Middle East, Africa and Eastern Europe where conservative religious views are strongly associated with politics. This provides the opportunity for the technical agencies (who do not have the right to provide text in the negotiations process) to answer questions and make the case for a PD closely aligned to Strategy2016 and the broad framing of public health put forward therein. It is also important to note that in the earlier stages of negotiations and in the technical briefings staff representatives from the diplomatic missions in New York are not technical experts in health and are more political in specialization. They are well versed in the religious and cultural conflicts prevalent in UN negotiations, but generally have less understanding of the HIV response.

In addition, the technical agencies develop and disseminate technical guidelines and support countries to collect data on the HIV response at national level including developing indicators for the monitoring and reporting of national responses to HIV. This provides both the country and the technical agencies with accurate data to guide national HIV responses. Key to addressing the epidemic is

an accurate knowledge of where new infections are occurring, among which population groups and in which locations, and how many people are on treatment. As this thesis will explore, stronger data at a national level on where, and amongst whom the epidemic is growing the fastest, can help counter resistance to implementing certain technical approaches to HIV prevention due to religious and social pressures.

The technical agencies work closely with Ministries of Health at a national level to help implement national AIDS programmes in line with the strategy. This helps to build strong national programmes, but also a cadre of health staff supportive of the policy frame put forward in the UNAIDS and WHO strategies at national level. Ministers of Health are often included in the national delegations to the negotiations in New York to provide technical advice to the final political negotiations. The technical agencies also work with the Ministries of Health to develop grant proposals to the Global Fund to fight TB, AIDS and Malaria. Funding flows follow the criteria for grant proposals drawn up by the Global Fund, which are in line with the UNAIDS and WHO strategies. Countries which have followed WHO guidelines and designed their national HIV response plans in line with Strategy2016 have seen declining rates of HIV infection among key populations, as data earlier in this chapter has demonstrated. These are also important strategies to support the framing of a public health approach to HIV in line with Strategy2016 at the UN, building on the rationale of doing more of what works.

Chapter 4. Human rights, gender equality and community engagement discourse

4.1 Introduction, key words and research questions

This chapter consists of a review of literature and practice across the three areas which constitute this very broad discourse: human rights, gender equality and community engagement in the context of the HIV response. Strategy2016 sets out a policy frame on these three issues (UNAIDS 2015c).

The main elements of the human rights, gender equality and community engagement discourse and policy frame will be drawn out from the current literature using the same suite of UN documents referenced in chapter 3, which were prepared in advance of the HLM on AIDS in 2016. This will be followed by an overview of the policy frame as it is set out in Strategy2016.

The literature in these three areas is huge and cannot be covered in full. For this reason, as explained in chapter 3, Strategy2016 and other documents have been chosen, which draw on systematic reviews of the broader literature, and build on previous policy documents and current data. In addition to identifying the main elements of the discourse, this chapter and the accompanying annex 4 will show how this information has been structured into a meaningful policy problem and solution in Strategy2016 in line with the definition of a policy frame by Verloo, as a standard against which PD2016 can be compared (Verloo 2016, 20).

The words and phrases associated with the human rights, gender equality and community engagement discourse on AIDS, identified through the literature review and close reading of the PDs include:

Human rights; fundamental freedoms; gender equity; inequality; women; girls; men; boys; young people; adolescents; social determinants; poverty; laws; policies; stigma and discrimination; risk; vulnerability; children; mother; mother to child; vertical transmission; sexual reproductive health and rights; reproductive rights; sexual violence; intimate partner violence; men who have

sex with men; sex workers; transgender; sexuality; enabling environment; empowerment; informed consent; age of consent; harmful practices; child marriage; rape; abuse; social protection; child protection; comprehensive information and education; participation; people living with HIV.

Annex 2.2 provides a graphical representation of the number of times terms indicative of this discourse appear in the text of each PD.

The chapter will seek to answer the following questions:

- What are the main elements of the human rights, gender equality and community engagement policy frame, as found in Strategy2016?
- What are the goals and targets, strategic directions and actions proposed by Strategy2016?
- What are the underlying conceptual frameworks informing the development of this discourse?
- What are some of the debates and tensions within the human rights, gender equality and community engagement discourse, relevant to this thesis?
- Who are the supporters of this discourse in policy negotiations at the UN and what are their strategies to position this as the dominant discourse?

4.2 Framing the discourse from the literature and practice of the HIV response

4.2.1 Main elements of the human rights, gender equality and community engagement policy frame as found in Strategy2016

4.2.1.1 UNAIDS Strategic direction 3: human rights and gender equality for the HIV response

As outlined in Chapter 3, Strategy2016 is based on the principles of human rights and gender equality, non-discrimination and the meaningful and measurable involvement of civil society, especially people living with HIV and key

populations most at risk of HIV infection (UNAIDS 2015c, 2).The WHO *Global Health Sector Strategy on HIV 2016-2021* also promotes a people-centred approach, grounded in principles of human rights and health equity (WHO 2016b, 7). Strategy2016 frames the problems caused by a lack of respect for human rights, gender equality and engagement of civil society in the HIV response, and provides core actions that countries can take to address human rights and gender equality across the entire spectrum of rights: civil, cultural, economic, political, social, sexual and reproductive (UNAIDS 2015c, 4).

4.2.1.2 Framing the problem from a human rights perspective

There are four main areas outlined in the literature and Strategy2016 on human rights and HIV: i) Punitive laws, policies and practices, which hinder access to services or infringe human rights; ii) HIV related stigma and discrimination, particularly in healthcare settings; iii) the importance of people living with HIV being able to know their rights, access legal help and challenge violations of human rights; and iv) that laws policies and programmes are in place to protect people living with HIV, and address violence against people living with HIV and key populations (UNAIDS 2015c, 11).

Where countries enact and enforce punitive laws, policies and practice these can violate the rights of individuals, specifically key populations, to access essential health and other services. Punitive laws, policies and practices are present in all regions and include criminalization of HIV non-disclosure, exposure and transmission (UNAIDS 2015c, 37). In 2016, laws specifically allowing for HIV criminalization were present in 72 countries (UNAIDS 2016c, 10).

Across sub-Saharan Africa 24 countries include provision in the law for criminalization of HIV non-disclosure, exposure or transmission. These negatively affect HIV responses and constitute an infringement of human rights (Eba 2016, 179). These laws are not simply a remnant of a historical past; 27 countries have introduced HIV specific laws in sub-Saharan Africa during the course of the epidemic and four countries passed new HIV criminalization laws between 1 April

2013 and 30 September 2015: Botswana, Côte d'Ivoire, Nigeria and Uganda (UNAIDS 2016c, 10) (Eba 2016, 183).

Punitive approaches to HIV undermine public health approaches as people will not seek HIV testing, treatment and care if they fear that they could face stigma and discrimination in healthcare settings and possibly prosecution (OHCHR 2006). These fears are further exacerbated when the behaviours of key populations, men who have sex with men, sex workers, people who inject drugs and transgender people are also criminalized (UNDP 2012).

Laws and policies are closely linked to societal attitudes. Where there is engrained cultural and religious discrimination towards people, based on their sexual orientation and gender identity, race, disability, drug use, being an immigrant, involved in sex work, or in prison, then HIV discrimination can be more difficult to eliminate from society and from legal and policy frameworks (UNAIDS 2015c, 14). When stigma and discrimination is deeply engrained in culture and society it also fuels stigma and discrimination in healthcare and other formal settings as the quotation in annex 4 demonstrates (UNAIDS 2015c, 37). This has a direct effect on the epidemic, as stigma in healthcare settings is closely linked to delayed HIV testing, non-disclosure to partners and poor engagement with HIV services, including treatment retention (Piot et al. 2015, 12).

Strategy2016 highlights as a priority the need to defend the rights of all vulnerable people including children, women, young people, men who have sex with men, people who use drugs, sex workers and clients, transgender people and migrants: with specific reference to the rights which affect their vulnerability to HIV infection and access to lifesaving treatment and care (UNAIDS 2015c, 37).

4.2.1.3 Goals and targets; strategic directions and actions on human rights proposed by Strategy2016

The goals and targets of Strategy2016 have been outlined in full in Chapter 3 and annex 3. To achieve these goals and targets Strategy2016 sets out one result and four outcomes to be achieved under SDG (16) Peace, justice and strong institutions (UNAIDS 2015c, 11) (see annex 4).

Strategy2016 calls on countries to promote human rights, gender equality, community engagement, equal opportunities and to build more inclusive societies. Countries are challenged to work with service providers in health-care, workplace and educational settings to eliminate HIV-related stigma and discrimination, including against people living with HIV and key populations. These actions draw heavily on the more detailed recommendations of the Global Commission on HIV and the Law (UNDP 2012, 97).

The Commission mentions the role of religious law and influence in several places in its report. For example, the call to 'work with the guardians of customary and religious law to promote traditions and religious practice that promote rights and acceptance of diversity and that protect privacy' (UNDP 2012, 7). The Secretary General in his report to the UN General Assembly commends the recommendations of the Global Commission for their consideration when drawing up the Political Declaration. Some, but not all of the recommendations are reflected in the text of the PD (Secretary-General 2016, 24).

UNAIDS has also developed a guidance note, outlining seven key programmes to reduce stigma and discrimination and increase access to justice in national HIV responses, which is now being used by the Global Fund to fight AIDS, Tuberculosis and Malaria to guide the development of national proposals to the Fund. This is important as it provides a practical mechanism for these principles and guidelines to be implemented in planning at national level and to direct funds towards specific programmes that address the human rights issues framed in the technical documents. These programmes include: 1. Stigma and discrimination reduction; 2. HIV-related legal services; 3. Monitoring and reforming laws, regulations and policies relating to HIV; 4. Legal Literacy ("know your rights"); 5. Sensitization of law-makers and law enforcement agents; 6.

Training for healthcare providers on human rights and medical ethics related to HIV; and 7. Reducing discrimination against women in the context of HIV (UNAIDS 2012b).

This section and annex 4 has briefly set out the policy frame on human rights and HIV that is articulated in Strategy2016. There are significant areas of tension between the human rights policy frame and a traditional religio-cultural discourse on HIV, which will be outlined in Chapter 5. These tensions can be identified in the negotiations towards and final text of the PDs and will be drawn out in Chapters 8 and 9.

4.2.1.4 Framing the problem from a gender equality perspective

In 2016 this same suite of documents articulates the policy frame on women, girls and HIV. This includes description of the factors which increase the risk and vulnerability of women and girls to HIV infection and its impact and sets out the actions that must be taken by governments to reverse the increasing HIV infection rates among young women.

The core documents reviewed in this section are the same as for the public health and biomedical and human rights framing. Two additional documents are of relevance for the negotiations: the resolution put forward by Botswana on behalf of the Southern African Development Community (SADC) to the Commission on the Status of Women adopted and included in the final report of proceedings (United Nations 2016a). (This is significant because the MS putting forward the resolution are numerous, and come from the continent where most young and adolescent women are being infected with HIV). Second, *The Global Strategy for Women's, Children's and Adolescents' Health (2016-2030)* (Secretary General 2015). Together these documents provide the technical and political policy framing of the HIV epidemic as it affects women and girls. Current data from the UNAIDS 2017 reports are added for comparison where available, but note that this data was not available when PD2016 was negotiated.

There is consistency across the documents in terms of the issues to be addressed. When it comes to the proposed solutions there is consistency among the technical agencies in the strategies, but not among MS.

Women and girls are more vulnerable to HIV infection than men and boys. Globally, AIDS is the leading cause of death among women of reproductive age. Men and boys however, have greater risk of death from AIDS-related illnesses. Deaths were '27% lower among women and girls in 2016 than they were among men and boys' (UNAIDS 2017d, 4). Whilst the number of deaths among women aged 15-49 dying from AIDS-related causes has decreased since 2010, young women and adolescent girls experience elevated HIV risk and vulnerability on an ongoing basis. In 2014, 63 percent of the 2.8 million young people aged 15-24 years living with HIV in sub-Saharan Africa were female; 56 percent of all new infections among those aged 15-24, and 62 per cent of new infections among those aged 15-19, were among girls and young women (Secretary-General 2016. 25). More recent data shows that:

> 'Differences in the number of new HIV infections between men and women are more pronounced at younger ages: in 2016, new infections among young women (aged 15– 24 years) were 44% higher than they were among men in the same age group. Since 2010, new infections among young women globally (aged 15–24 years) have declined by 17%, reaching 360 000 [210 000–470 000] in 2016. New infections also declined among young men (aged 15–24 years) during that time, falling by 16% to 250 000 [110 000–320 000] in 2016' (UNAIDS 2017d, 6).

UNAIDS data from South Africa indicates that approximately 2000 young women age 15-24 are infected with HIV every week; approximately 12 per hour (UNAIDS 2017a).

The factors which put women and girls at increased risk of HIV infection are complex and include: a physiological vulnerability that is greater than in men, (though this is not the dominant factor); restriction of their human rights and fundamental freedoms (including inheritance rights) compounded by

discrimination and violence, including rape and intimate partner violence, which is increased in situations of conflict and humanitarian disasters; barriers in access to sexual and reproductive health information and services; limited HIV prevention options that are controlled by women; limited opportunities for education, in particular to receive comprehensive sexuality education; and gender inequality, including economic disadvantage and poverty, an increased burden of unpaid domestic care work and lack of autonomy and decision making power (Secretary-General 2016). (See annex 4).

4.2.1.4.1 Gender-based and intimate partner violence

One element of this increased vulnerability is violence, including intimate partner violence.

All forms of violence, including gender-based, sexual and intimate partner violence, may increase a woman's risk of acquiring HIV. Young women and adolescent girls have the highest incidence of intimate partner violence; in some settings, up to 45 percent of adolescent girls report that their first sexual experience was forced. Young women who experience intimate partner violence are 50 percent more likely to acquire HIV than other women (UNAIDS 2015c, 37).

Sexual violence is increased in situations of conflict and crisis, and in these situations young women are often unable to protect themselves. Reported rates of sexual violence in conflict situations vary. Analysis of 19 studies found that an average of 21.4 percent of women displaced by complex humanitarian crises reported some form of sexual violence or exploitation (Vu et al. 2014). In 2011 the Security Council adopted resolution 1983, which focused international political attention and action towards ending conflict-related sexual and gender-based violence and empowering women to reduce their vulnerability to HIV (Security Council Resolution 2011, Secretary-General 2016).

Other violations of women's rights include discriminatory laws and harmful practices such as forced marriage, female genital mutilation and restrictions on women's equal access to decision-making, education, employment, property,

credit or autonomy. These violations can also prevent them from access to services and care, which further compounds vulnerability to HIV (UNAIDS 2015c, 14) (UNAIDS 2015c, 37).[6]

Sex workers and transgender women are some of the most vulnerable women. HIV infection rates among sex workers are documented have to reached levels of 71.8 percent in Johannesburg in 2015 (UNAIDS 2016c, 10).

HIV prevalence among sex workers in Botswana, Rwanda, Swaziland and Zimbabwe can be 45 percent or more. Median HIV prevalence rates for sex workers across Africa are around 20 percent. Rates of 8.4 percent have been recorded in the Caribbean. The four main reasons for these high prevalence rates are violence, criminalization, stigma and discrimination and the lack of programmes to meet their needs (Piot et al. 2015, 11).

Transgender women are also at particular risk; 19 percent are estimated to be living with HIV. These rates are highest among transgender women who inject drugs and or sell sex. In many parts of the world stigma and discrimination towards sex workers and transgender women are high and violence is common (Piot et al. 2015, 13).

4.2.1.4.2 Rights, roles and responsibilities of men in ending AIDS

In 2015, UNAIDS hosted a high-level consultation to explore the rights, roles and responsibilities of men in ending the HIV epidemic and in 2017 issued a special report entitled ‘Blind Spot’ highlighting the challenges of addressing HIV infection and AIDS related deaths among men (UNAIDS 2017b). This group is neglected in the literature and in the HIV response. The background discussion paper prepared for this meeting, and ‘Blind Spot’ review the current literature and evidence, points to persistent and pervasive gender inequality in the very

[6] (The) 20-year review of the Beijing Platform for Action found that, even where legal equality has been achieved, discriminatory social norms remain pervasive, which affects all aspects of gender equality, women’s empowerment and women’s and girls’ human rights (UNAIDS 2015c, 37).

structure of society, which gives men power and privilege disproportionate to women, and promotes social roles, expectations and gender norms, which not only reinforce the dominance of men and subordination of women, but also lead to harmful socialization of boys and, consequently to behaviours that put men at greater risk of illness, death and violence (UNAIDS 2015a, 7) (UNAIDS 2017b).

Globally 49 percent of people living with HIV are men and adolescent boys older than 15 years. Of that global male population living with HIV in 2015, about 10 percent were adolescent boys and young men, of which 64 percent were in sub-Saharan Africa, and 20 percent in Asia and the Pacific (UNAIDS 2015a, 10). Globally there are approximately 1.8 million new HIV infections among adults, of which approximately 52 percent are among men age 15-49 years. 'Outside of eastern and southern Africa, men accounted for about 60% of the estimated 950 000 new HIV infections among adults 15 years and older in 2016, and 58% of adults living with HIV in these regions were men' (UNAIDS 2017b, 8). Among young people aged less than 25, however, the vulnerability is greater among young women, as previously explained (UNAIDS 2015a, 10, 2017d).

Globally, there were approximately 1.2 million [980,000 – 1.6 million] AIDS-related deaths in 2014, out of which men constituted almost 60 percent and made up the majority of AIDS-related deaths in every region of the world. 58 percent of the global AIDS-related deaths among men occurred in sub-Saharan Africa , followed by Asia and the Pacific (26 percent), Latin America (5 percent) (UNAIDS 2015a, 12). Current data shows that 'Men are more likely than women to die of AIDS-related causes: globally, they accounted for about 58% of the estimated 1.0 million [830 000–1.2 million] AIDS-related deaths in 2016' (UNAIDS 2017b, 5).

These figures mask a diverse range of vulnerabilities, which the literature and the consultation unpack in further detail. Gay men and other men who have sex with men have high prevalence rates of HIV, rising up to over 40% in some countries, with higher prevalence rates in some urban areas (UNAIDS 2017b, 16).

4.2.1.5 Goals and targets, strategic directions and actions on gender equality proposed by Strategy2016

The goals and targets of Strategy2016 have been outlined in Chapter 3 and appendix 3. To achieve these, Strategy2016 also sets out one result and five outcomes to be achieved under SDG 5 Gender equality (see annex 4). [7]

This section and accompanying annex 4 has set out the evidence from the literature and Strategy2016 of the different risks and vulnerabilities faced by men and women to HIV infection. It has articulated some of the issues that put the different groups at increased risk and demonstrated that the risks put forward result in increased rates of HIV infection and death in different groups. It has also highlighted the social norms, including stigma, discrimination, violence and criminalization of certain groups, which exacerbate these risks and hinder people from accessing HIV services. Together this data and these arguments provide the rationale for the goals, targets, strategic directions and actions proposed in Strategy2016 and constitute the framing of the problem for the policy actions put forward as a solution.

This section and annex 4 have gone into some considerable detail in the framing of both the problem and the recommendations as they appear in Strategy2016, because this has been negotiated and adopted by MS at the UNAIDS PCB in 2015 and should therefore provide agreed consensus text for use in the 2016 PD. This constitutes the policy frame on women, girls and key populations articulated in Strategy2016. Yet, only two months after Strategy2016 was adopted, when the PD was negotiated and adopted in New York, important elements of these recommendations were missing from the final text of the 2016 PD. Later sections of this thesis will explain what is missing and why.

4.3 Conceptual Frameworks

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[7] The United Nations Millennium Development Goals (MDGs) included reference to “gender equality” in one of the eight targets to be achived by 2015.

There are four conceptual frameworks of relevance to this thesis, three of which underpin Strategy2016 (see section 2.2). Chapters 9 and 10 will revisit these conceptual frameworks to analyse potential areas of conflict and synergy.

An additional note on the gender mainstreaming conceptual framework (CEGM), as articulated by the Council of Europe is of relevance here (Council of Europe 1998). The CEGM is of particular importance for the policy frame articulated in this chapter as it calls for action to change the structures in society which maintain unequal power relationships relating to gender, which lead to vulnerability and marginalization. The extent to which the PD picks up the details of the goals, targets, strategies and core actions laid out in the UNAIDS and WHO 2016-2021 Strategies on HIV, with respect to changing the structures that maintain unequal power relationships will be discussed in chapters 9 and 10. The willingness or unwillingness to challenge existing power structures, particularly where these put people at risk of HIV infection and increase its impact is where the crux of the battle between the discourses lies.

4.4 Development and debates

There are multiple origins of the discourse on women's sexual and reproductive health and HIV. Many authors have documented the battle between women and power structures in society dominated by a largely male medical and religious leadership. Several theses could be written to explore the development of this historical discourse in full. The purpose in this thesis however, is to briefly locate the current discourse around gender equality and HIV within a broader discourse. Chapter 5, annex 4 and 5, each include a brief discussion of the history and conflict between gender equality and a traditional religio-cultural discourse.

4.4.1 Community engagement

Community engagement is a central element of the human rights, gender equality and community engagement discourse. In addition communities have played an active role in the development and debates on Strategy2016.

Community engagement is not articulated as a separate policy frame in Strategy2016; rather community engagement, civil society action and activism are woven throughout the Strategy.

This section and annex 4 attempt to draw out the main elements of the policy frame on community engagement from Strategy2016 as well as other recent and relevant literature. The purpose of this section is to highlight the main issues in the current discourse, including the results and core actions articulated in the Strategy that should be reflected in the 2016 PD, so that these can be tracked in the analysis that follows in chapter 8.

Communities have been engaged in the HIV response since the beginning of the epidemic and have been central to ensuring people are reached with HIV treatment, prevention, care and support services, advancing human rights, and challenging gender inequalities (UNAIDS and Stop AIDS Alliance 2015, 6). Civil society engagement, activism and advocacy has also been a critical factor in addressing stigma and discrimination and calling for action to remove 'overly broad' criminalization, punitive laws and policies and increase access to essential health and legal services by key populations (UNAIDS 2015c, 37).

Strategy2016 builds on these recent publications and literature, which document the community response. Most importantly it calls for commitment to the Greater involvement of people living with HIV and AIDS (GIPA) principle, which underpins community engagement and is one of the defining features of the HIV response that differentiate it from responses to other diseases (UNAIDS 2015c, 39).

This chapter and the accompanying annex 4 provide an overview of human rights, gender equality and community engagement and demonstrate that they are a linked discourse, which has been articulated as a policy frame within Strategy2016. These sections have highlighted in particular three sets of results and core actions necessary to achieve the goals and targets in these areas as highlighted in chapter 3. Analysis will explore where the areas of tension are between this framing and the traditional religious discourse, and how this is

evident in what is included, and what is left out of the text of the 2016 PD. This is described in Chapters 8 and 9.

4.5 Supporters and Strategies

This section outlines the supporters of the public health, biomedical, human rights and gender equality discourses in the policy-making space at the UN, and highlights the strategies and methods used for providing support.

As with the public health discourse, the discourse of human rights, gender equality and community engagement is supported by UNAIDS and WHO, the lead technical agencies on AIDS, by the other UNAIDS Cosponsors and by WEOG countries, many Latin American countries, South Africa and other nations supportive of a broad definition of public health based on evidence, rights and gender equality.

Strategies to support human rights, gender equality and community engagement in policy-making on HIV are similar to those employed by this same group, in support of the public health and biomedical discourse.

The main strategies are to provide data and evidence that links approaches supportive of human rights, gender equality and community engagement with reduced HIV infection rates and increased numbers of people accessing and staying on treatment, and the converse. This data is used to inform the development of the policy frame set out in the UNAIDS and WHO 2016-2021 Strategies, and in the accompanying guidelines documents for country implementation. Technical staff from these agencies also support governments at national level to develop national plans and funding proposals in line with the evidence and the policy framing. They work closely with staff from Ministries of Health to build national capacity to address these issues through the programmes, but also in national policy-making debates.

During negotiations MS supportive of these positions will provide language on human rights, gender equality and community engagement to strengthen the

text. Evidence of the supportive positions on human rights, gender equality and community engagement of MS in policy-making debates can be found in the public statements made by MS at the adoption of the PDs and other similar documents.

Chapter 5. Traditional Religio-Cultural discourse

5.1 Introduction, key words, research questions

This chapter provides an overview of the traditional religio-cultural discourse on HIV as articulated by the Holy See and others at the UN. The literature to be reviewed includes formal documents of the UN, the Vatican and texts authored by supporters of this discourse. In section 5.4 and annex 5 the development, debates, supporters and strategies of this discourse, and analysis by other authors is also reviewed, some of whom are critical of the traditional religio-cultural discourse. This discourse has developed over the last six decades, and the literature is extensive. This review cannot be exhaustive, but texts have been selected which provide an overview of the discourse, content and development of its conceptual and theological frameworks and analysis of the conflicts and tensions between this discourse and others at the UN in policy-making on HIV and SRHR.

The words and phrases associated with the traditional religio-cultural discourse on HIV as identified through the literature search and a close reading of the PDs include:

Families; abstinence; fidelity; faith; religion; culture; disability; values; ethical; spirit/spiritual; moral support; prostitute; educating and guiding children; marriage/married; ensuring safe and secure environments; safety, humanity; age appropriate; consistent with evolving capacities; justice; dignity; belief; responsible sexual behaviour; vulnerab/le/ility; parent

As explained in Chapter 2, a frame mapping was conducted and annex 2.2 provides a graphical representation of the number of times terms indicative of this discourse appear in the text of each PD.

This chapter will seek to answer the following questions:

- What are the main elements of the traditional religio-cultural discourse as it appears in policy-making on HIV, SRHR and women and girls at the UN?
- What are the underlying conceptual frameworks informing the development of the discourse?
- What are the main developments and debates in and around this discourse relevant to this thesis?
- Who are the supporters of this discourse in the policy negotiations at the UN and what are their strategies to position this as the dominant discourse?

5.2 Framing the discourse from the literature and practice of the HIV response

The traditional religio-cultural discourse is not articulated as a policy frame (as defined by Verloo) in one single document in the same way as the public health discourse is framed in Strategy2016. The discourse does however, take a range of fragmentary and 'incidental information and transform it into a meaningful policy problem in which a solution is… enclosed'(Verloo 2016, 20), as this section will attempt to demonstrate. Supporters of this discourse represent a number of actors, predominantly conservative religious communities and Member States. What unites these supporters is a conservative perspective on matters of SRH, gender and HIV (involving opposition to abortion, same-sex marriage, legalisation of sex work and drug use and comprehensive sex education). Proponents seek to promote these perspectives in UN policy debates through rigid application and conservative interpretation of the declarations and treaties on human rights. Religious voices within this discourse tend to belong to conservative religious groups whose beliefs and values are shaped by traditional interpretations of sacred texts such as the Hebrew Scriptures, Christian Bible and Holy Quran. A common approach taken by supporters of this discourse involves appeal to the natural law, whereby certain types of behaviour are regarded as natural/normal/morally appropriate and other behaviours regarded as unnatural/abnormal/immoral. Natural law theory will be discussed in more detail in section 5.3.1. Proponents of this discourse also advocate strongly for national sovereignty, religious freedom (for religion and its structures), and non-

interference in cultural practices. This is put forward in contrast to what is perceived as an attempt to erode traditional cultural values and to impose a secularising and liberal human rights agenda by economically powerful elite nations.

Before describing the elements of the traditional religio-cultural discourse and the associated policy frame, it is important to point out that core elements of the traditional religio-cultural discourse are enshrined in the Universal Declaration of Human Rights (UDHR) and are shared by many religious and state actors at the UN. There is consensus across all stakeholders on fundamental human rights, including: every person has inherent dignity and entitlement to human rights; the right to life itself; the family unit is central to society and should be respected and protected; parents play a critically important role in educating their children; and individuals should have the freedom to practice a religion of their choice. There are differences however, indeed there is a continuum of thought, on how they are interpreted and applied. One group of actors, has come together at the UN to push forward one interpretation and constellation of issues, to the exclusion of other interpretations and actors. The resulting polarization has eclipsed the true breadth and nuance of this very wide debate.

Conflict and tension arise when this group of actors interpret these principles and rights in very specific and limited ways and seek to impose these interpretations through international policy and legislation on others. The traditional religio-cultural approach positions family as sovereign and in possession of rights that must be respected by the state; and interprets human dignity and human rights enshrined in the UDHR through the application of ‘natural law’, considered applicable to all, regardless of whether people adhere to religious belief or not (Adolphe 2006, 348). This approach fails to recognize that there is an important role for the state in providing safeguards for the individual against abusive power of the collective in the name of family, marriage or religion. Other groups seek to expand and apply these fundamental rights more broadly, in ways that were not commonly or openly discussed when

they were originally drafted. This expansion of rights leads to clashes over the definitions of gender, marriage, family, sexual education and health services.

Section 5.5 and annex 5 will explore further how supporters of these traditional interpretations operate at the UN to ensure that the traditional religio-cultural discourse is the dominant discourse in policy on some of these specific issues. Chapters 8 and 9 will explore the extent to which the traditional religio-cultural discourse is evident in the negotiations and text of the PDs on HIV & AIDS.

5.2.1 Main elements of the traditional religio-cultural discourse as it appears in policy-making on HIV, SRHR and women and girls at the UN.

From my broad review of the literature and interventions at the UN on HIV and SRH, I have identified these 12 elements as central to this discourse. They are repeated in different documents, negotiations, literature and side events. This section attempts to capture each element and provides an example of where it is stated in a formal document or intervention.

Each human being has inherent human dignity and is entitled to the same rights as others.[8]

> All human beings are born free and equal in dignity and rights. They are endowed with reason and conscience and should act towards one another in a spirit of brotherhood (General Assembly Resolution 1948, 1).

The right to life is an inalienable right, which begins at conception through to natural death.

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[8] This affirmation of the inherent dignity of the human person is reaffirmed in a series of subsequent declarations and conventions adopted by Member States, e.g.: the International Covenant on Civil and Political Rights (1996), International Covenant on Economic, Social and Cultural Rights (ICESC) (General Assembly Resolution 1966), Convention on the Rights of the Child (CRC) (General Assembly Resolution 1989) and the Convention on the Elimination of All Forms of Discrimination against Women (1979).

> Everyone has the right to life, liberty and security of person (General Assembly Resolution 1948, 3).

Abortion is unacceptable, given the inalienable right to life.

Positions vary within the traditional religio-cultural framing on family planning; some conservative religious positions reject all forms of modern contraception as defined by WHO (WHO 2016a).

> States Parties recognize that every child has the inherent right to life. States Parties shall ensure to the maximum extent possible the survival and development of the child (General Assembly Resolution 1989, 6:1, 2).

The family is the natural unit of society, the natural place for children to be raised, fundamental to peace and development. It should be defended by the State and international organizations

> The family is the natural and fundamental group unit of society and is entitled to protection by society and the State (General Assembly Resolution 1948, 16.3).

The right to marry and found a family is central to many other rights, and fundamental for development and a stable and just society.

The family, whilst it appears in different forms, is defined within this traditional framing as one man married to one woman and their natural or adopted children; this definition remains unchangeable.

> Men and women of full age, without any limitation due to race, nationality or religion, have the right to marry and to found a family. They are entitled to equal rights as to marriage, during marriage and at its dissolution (General Assembly Resolution 1948, 16.1).

> Marriage shall be entered into only with the free and full consent of the intending spouses (General Assembly Resolution 1948, 16.2).

Reproduction, the bearing and raising of children, motherhood and parenting have a special status and should be afforded protection and care by society and the State.

> Motherhood and childhood are entitled to special care and assistance. All children, whether born in or out of wedlock, shall enjoy the same social protection (General Assembly Resolution 1948, 25.2)

Men and women have the right to choose a religion and practice it according to their beliefs.

States have the responsibility to protect this right.

> Everyone has the right to freedom of thought, conscience and religion; this right includes freedom to change his religion or belief, and freedom, either alone or in community with others and in public or private, to manifest his religion or belief in teaching, practice, worship and observance (General Assembly Resolution 1948, 18).

Parents have the right to choose the education for their children, especially on sexual and reproductive matters, in line with their cultural and religious beliefs

> Parents have a prior right to choose the kind of education that shall be given to their children (General Assembly Resolution 1948, 26.3).

Gender refers to biological sexual identity and the difference that is male or female.

> For the purpose of this Statute, it is understood that the term “gender” refers to the two sexes, male and female, within the context of society.

The term “gender” does not indicate any meaning different from the above (General Assembly Resolution 1998, 7.3).

Regarding the concept of “gender norms” the Holy See does not recognize the idea that gender is socially constructed, rather gender recognizes the objective identity of the human person as born male or female (Holy See 2016).

The following elements of the framing are not enshrined in the resolutions of the UN General Assembly or the International Criminal Court, but have either been put forward by the Holy See, or in Member State interventions at the UN, or are included in the Pontifical Council on the Family document, *The Family and Human Rights* (Pontifical Council for the Family 1999).

Sexual activity is limited to married couples (and marriage is reserved for one man to one woman) therefore the provision of sexual and reproductive health services by governments should be to couples not individuals.

Responsible sexual behaviour refers to sexual abstinence before marriage and sexual fidelity within marriage. (Interventions from Jordan, Egypt, the Holy See, Libyan Arab Jamahiriya and Iran supporting these elements of the discourse are cited by UNFPA (UNFPA 2016, 122-132)).

Member States have a sovereign right to define their political, economic and social way of life, their religious, cultural and development priorities, and to enshrine these in national or religious law.

Other countries do not have the right to impose their views on Member States (Libyan Arab Jamahiriya cited by UNFPA) (UNFPA 2016, 124).

Some civilizations ought not to impose their own way of life on other civilizations under the pretext of human rights protection. The human rights activity should not be put at the service of interests of particular countries (Russian Orthodox Church 2010, III 4).

Sex work, injecting drug use, and sex between members of the same sex are rightly prohibited by religious traditions and national law in many countries; these laws should be upheld and protected.

Under the auspices of The Economic and Social Council (ECOSOC), the Commission on the Status of Women (CSW) was established in 1946 (Economic and Social Council Resolution 1946) and was involved in the drafting of the UDHR. As early as 1950, the CSW supported the development of the Convention for the Suppression of the Traffic in Persons and of the Exploitation of the Prostitution of Others, which states in the preamble that 'prostitution and the accompanying evil of the traffic in persons for the purpose of prostitution are incompatible with the dignity and worth of the human person and endanger the welfare of the individual, the family and the community'(General Assembly Resolution 1950). This positions sex work as associated with evil, with trafficking, as incompatible with human dignity and a threat to the family and the community. This framing later becomes an important part of the traditional framing of sex work in discourse around the HIV response.

5.2.2 Origins and sources of the traditional religio-cultural framing

Concepts within the traditional religio-cultural framing have been in existence for a very long time; elements of this framing are traditional and have origins in ancient religions and cultures.

An articulation of the elements of the frame in international policy documents, particularly as it relates to marriage, the family, SRH and the rights of parents, women, children and young people can be traced back to the UDHR in 1948 (General Assembly Resolution 1948). For the purposes of this thesis, consideration of traditional religio-cultural framing as applied to the issues of family, women and young people is pertinent because of the close links between these issues and the HIV response.

Because the Roman Catholic Church is the world's largest religious group (with over 1.2 billion adherents (Hackett 2017) (Vatican 2017)) and because of the special status of the Holy See at the UN and therefore its considerable influence, the theological concepts and moral teachings of the Roman Catholic Church are central to this discourse. Catholic teaching on sex and family life is conservative and absolutist. This conservative, even hard-line, approach commands support across a range of interest groups and religious communities, including Eastern Orthodox Christians, conservative evangelicals, and nation states with an avowedly conservative religious (Islamic or Eastern Orthodox) cultural and political identity. For this reason, the Holy See has become a focal point for conservative advocacy on matters of gender equality, SRH and HIV, as will be seen below.

Supporters of the traditional religio-cultural discourse have repeated and strengthened their interpretation of the UDHR and other resolutions,[9] in subsequent international documents for over 60 years. The discourse became more intense from 1994 with the UN year of the family, followed by the Cairo conference on population and development and the Fourth World Conference on Women in Beijing in 1995 (Adolphe 2012) (annex 5 provides a summary of this intense debate).

Recognizing that there is a wide range of actors supporting this discourse as articulated by the Holy See, there are three documents of particular importance to Roman Catholic partners for the framing of this traditional discourse: the *Universal Declaration of Human Rights* (UDHR), the *Encyclical Letter Humanae Vitae of the Supreme Pontiff Paul VI* (Pope Paul VI 1968); and Catholic teaching in *The Family and Human Rights* (Pontifical Council for the Family 1999). This document by the Pontifical Council for the family has been carefully crafted to articulate the Catholic teaching on the family in line with the UDHR. At the end of the document it puts forward a 'Charter on the Family', which includes the

[9] International Covenant on Civil and Political Rights (1996), International Covenant on Economic, Social and Cultural Rights (ICESC) (General Assembly Resolution 1966), Convention on the Rights of the Child (CRC) (General Assembly Resolution 1989) and the Convention on the Elimination of All Forms of Discrimination against Women (1979)

main elements common to the traditional religio-cultural framing and the UDHR as outlined above (Pontifical Council for the Family 1999).

Jane Adolphe[10] describes the linkages between the UDHR and the Holy See's teaching on marriage and family drawing on these texts. Taking UDHR Article 1 as a starting point, Catholic teaching builds on the idea of the innate dignity of men and women with several additional steps. Firstly, that people from their position of innate dignity can move to a position of 'acquired dignity', which perfects their innate dignity by operating in accordance with 'right reason' *(*Pontifical *Council for the Family 1999, 13)* (Adolphe 2006, 345). Right reason comes about through character training, education and faith (Adolphe 2006, 361).

The second step in the argument is that the development and outworking of this right reasoning is within the context of the natural family. Adolphe is clear that the 'natural family' follows a 'logical sequence' from right reason. It is the place where reason can grow and develop and marriage between a man and a woman is the natural consequence of its growth (Adolphe 2006, 346).

A second thread in this argument is that human beings are created male and female and created in the image of God. From this their dignity is derived. This assertion holds true for all persons, as it is part of a 'natural law', which is explained in section 5.3.

> In this way, one can argue that the human person's essential dignity is that he or she is created in the image and likeness of God.
>
> The above discussion does not require a faith-based acceptance; however, if taken as principles to which one arrives by reason, they certainly are more remote conclusions of natural law (Adolphe 2006, 348).

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[10] Jane Adolphe, Associate Professor of Cannon law at the Ave Maria School of Law in Rome represented Papal Nuncio and delivered interventions of the Holy See at the UN High Level Meeting on HIV/AIDS in 2011.

From this concept of men and women created in the image of God, flows the right to life and the unacceptability of abortion from a Catholic perspective (Pontifical Council for the Family 1999, 31, 34). The document makes the link to Article 3 of the UDHR to support this (General Assembly Resolution 1948, 3).

The next steps in the argument are that men and women have equal dignity but are complementary in their sexual dimensions. They cannot be fully themselves except through the gift of self to another and the natural result of that gift is marriage and family (Adolphe 2006, 348). Julie Clague in her discussion of the intersection of moral theology and gender studies points out that the concept of complementarity is a relatively new idea in Catholic teaching, (Clague 2011, 289). This complementarity of men and women, joined in marriage is then likened to the very nature of God. They are complementary: "God created man in his image; in the divine image he created him; male and female he created them" (Gen 1:27). To manifest that human beings are the image of the trinitary God, they must unfold their existence according to two complementary modes: the masculine and the feminine. Human existence is thus sharing in the existence of a God who is a communion of love (Pontifical Council for the Family 1999, 59).

The next step in this argument is that marriage is by nature intended to produce and educate children (Pope Paul VI 1968, 9), and that the primary responsibility for raising and educating children lies with parents. In this regard the State is obliged to provide the necessary support to parents (Pontifical Council for the Family 1999, 47). Adolphe goes as far as to say that the family in this regard is sovereign and has rights, linking this idea back to Article 16 of the UDHR (Adolphe 2006, 365).

The final step is to link this teaching to the sovereignty of Member States. The Pontifical Council document on the family and human rights does this in two ways. First, it states that ‘to defend the sovereignty of the family is to contribute to the sovereignty of nations’ (Pontifical Council for the Family 1999, 72). Paragraph 73 continues:

> What is worse is that under the impulse of international public organizations, presumably "new models" of the family are being put forth which include single parent homes and even homosexual unions. Some international UN agencies, supported by powerful lobbies, wish to impose "new human rights" on sovereign nations, such as "reproductive rights", which include access to abortion, sterilization, easy divorce, a "lifestyle" for young persons that favours the trivialization of sex, and the weakening of parents' lawful authority in their children's education (Pontifical Council for the Family 1999, 73).

Adolphe's analysis is significant because it is characteristic of the interpretation of UNDR on marriage and family put forward at the UN by the Holy See in negotiations on HIV & AIDS. It is very similar to the argument put forward by the Russian Orthodox Church (see annex 5).

5.3 Conceptual Frameworks

5.3.1 Natural law theory

There are many theories of Natural law (NL), which have roots in ancient religions and philosophical thought. NL theories exist in religious and non-religious groups, for example there are Jewish, Muslim and Buddhist approaches to NL. Although Protestants are influenced by NL thinking on matters of HIV, gender and SRH this section will focus primarily on Catholic approaches to NL. This is because NL theory is the conceptual framework that is repeatedly cited by the Holy See as a foundation for their interventions at the UN. This perspective on NL put forward at the UN reflects only one conservative end of a much broader debate on NL both within and outside of Catholicism.

There is no single official document outlining Catholic teaching on Natural law, however, the Catechism provides one useful digest of Catholic teaching on natural law and is the document cited in support of interventions by the Holy See on HIV and SRH at the UN. Chapter 2 and annex 1 explain how this is used as a conceptual framework for this discourse.

A more detailed examination of Catholic teaching on NL was developed in 2009 by the International Theological Commission (ITC) of the Catholic Church, entitled *In Search of a Universal Ethic: A New Look at the Natural Law* (ISUE) (International Theological Commission 2009). This provided a fresh examination of Catholicism's longstanding search for a universal moral ethic; and reflection on the question of whether there are objective and universal moral values that unite human beings. (Berkman and MattisonIII 2014, 2). This does not have the status of official Church teaching, but is written by Catholic theologians to help others understand Catholic teaching.

5.3.1.1 What is natural law theory?

NL theory can be described as humanity's attempt to articulate right, wrong and a moral code for humanity. Catholics and other religious adherents of NL, would say that the moral requirements of NL involve living in accordance with our nature and the God-given design of creation/the cosmos.

The ISUE outlines three key features and characteristics of the approach to NL:

- The belief that there is an objective moral law that applies to all people in all times and places (i.e. is universal).
- The belief that, using reason, all humans can access the moral law, which is the law of our nature.
- That NL confirms (rather than denies) Biblical law (International Theological Commission 2009).

Within the question 'Are there objective moral values which can unite human beings and bring them peace and happiness?' (International Theological Commission 2009, 1) there are three important elements. First, that NL can unite all people because it is accessible to all through reason and is not intrinsically linked to any one tradition or religion; it therefore has the capacity to unite all. Second, NL can bring peace and happiness as it is able to guide people on how to live well, and live together well by providing norms for peaceful relations. Third, NL 'procures' unity, peace and happiness for people when people live in accordance with its principles (Berkman and MattisonIII

2014, 8, 9). Whilst there is a recognition in many religions that sin clouds judgement, NL theory asserts that in general, humans are inclined to do the right things, for example to protect and preserve life, to care for children, to build communities etc. People do not need religion to tell them these things (this would be religious law). Common concepts of good and bad behaviour are found in many societies. The ISUE discusses these common beliefs in some detail and is clear that ‘Christianity does not have the monopoly on the natural law. In fact, founded on reason, common to all human beings, the NL is the basis of collaboration among all persons of good will, whatever their religious convictions’ (International Theological Commission 2009, 9).

The ISUE refers to the UDHR as a specific attempt to define this universal ethic; calling it ‘one of the most beautiful successes of modern history’ commenting that it ‘remains one of the highest expressions of human conscience in our times’. This is important, because it confirms that Roman Catholic Church teaching is supportive of the UDHR, as section 5.5. discusses in more detail.

5.3.1.2 Challenges to NL and the Catholic Church’s response

The ITC concedes that there have been times when some positions were justified by the Church based on NL, which were a result of the cultural and historical context. Examples would include invoking NL to justify slavery, racism, and sexism. NL is put forward by the Catholic Church as a universal set of principles, and yet the Church also admits that it cannot command universal support across time and cultures. For this reason this conceptual framework is problematic and for some, this undermines the claim that NL reflects a common morality and provides a universal ethic on the basis of reason (International Theological Commission 2009, 10).

The ISUE also articulates four current challenges where the Catholic Church responds with an appeal to NL; i) an over-emphasis on reason that leads to moral relativism; ii) in the face of ‘relativistic individualism’ that undermines ethical values; iii) to counter ‘aggressive secularism’, here it argues that the Church and Christians have a critical role in public life ‘on subjects that regard natural law (the defence of the rights of the oppressed, justice in international relations, the defence of life and of the family, religious freedom and freedom of education)’; and iv) when confronted with the abuse of power by the state. In

this case 'the Church recalls that civil laws do not bind conscience when they contradict natural law and asks for the acknowledgment of the right to conscientious objection, as well as the duty of disobedience in the name of obedience to a higher law' (International Theological Commission 2009, 35). These areas of tension are apparent in the interventions of the Holy See at the UN on issues of HIV and AIDS as later sections of this thesis will discuss in more detail.

5.3.1.3 The Catholic Church's use of NL in relation to HIV and SRH

The Catholic Church's understanding of 'sins against nature' especially with regard to sexuality underpin many the Holy See's interventions at the UN on HIV.

With regard to the UDHR, the family and SRH, Catholic documents in which the theory is expounded include *Humanae Vitae (Pope Paul VI 1968),* The *Family and Human Rights (Pontifical Council for the Family 1999),* the *Catechism of the Catholic Church* (Catholic Church 1997a, b) and the statements and letters of the respective Popes.

For example, *Humanae Vitae* states: 'the moral teaching on marriage…is based on the natural law as illuminated and enriched by divine Revelation' (n. 4); 'The Church…in urging men to the observance of the precepts of the natural law…teaches that each and every marital act must of necessity retain its intrinsic relationship to the procreation of human life' (n. 11); and 'The family is the primary unit in the state; do not tolerate any legislation which would introduce into the family those practices which are opposed to the natural law of God' (n. 23). The *Family and Human Rights* states: 'The bond between the *mother and the conceived child*, and the irreplaceable function of the *father* make it necessary for the unborn child to be welcomed into a family which assures, as far as possible and in accordance with natural law, the presence of its mother and its father (Pontifical Council for the Family 1999, 44). This teaching is framed most clearly in the Catechism, therefore annex 1 lists the relevant references to natural law in the Catechism which relate to the traditional religio-cultural discourse. Annex 1 lifts the relevant definitions, assumptions and key concepts from the Catechism into a table for comparison against the other conceptual frameworks, which underpin other discourses operational in the PDs.

5.4 Development and debates.

5.4.1 Amoris Laetitia

Pope Francis brings Catholic teaching on marriage and family life up to date in his Exhortation *Amoris Laetitia,* in which he makes only one reference to NL. Whilst NL is not a central theme in *Amoris Laetitia* the document repeats and reaffirms the main elements of Catholic Church teaching on marriage and family life. The tone of the document is one of mercy and grace, but the content of the teaching on SRHR does not shift significantly; the main elements of the traditional religio-cultural discourse are re-affirmed. The sections at the beginning of *Amoris Laetitia* reaffirm the argument that marriage is between a man and a woman and the production of a child is a reflection of the Holy Trinity.

> The ability of human couples to beget life is the path along which the history of salvation progresses. Seen this way, the couple's fruitful relationship becomes an image for understanding and describing the mystery of God himself, for in the Christian vision of the Trinity, God is contemplated as Father, Son and Spirit of love (Pope Francis 2016, 11).

The fruitfulness of the marriage in producing children is presented as central to the concept of marriage in paragraph 13. The production of children is central to the transmission of the faith down the generations in paragraph 29. The responsibilities of parents to teach their children the faith and for children to care for parents in old age are repeated in paragraph 17. Paragraph 23 mentions dignity, making an inherent link between dignity and work. In paragraph 34, assertion of individual rights is mentioned as a trend which relegates the development of relationships as 'subject to desires and circumstances' (Pope Francis 2016). An in depth analysis of the text of *Amoris Laetitia* is beyond the scope of this thesis, but this brief review is included here to demonstrate the consistency of Catholic social teaching and that despite public media discussion of the different approach of Pope Francis, the doctrine on these issues has not

shifted significantly, and his other statements reinforce this view (Pope Francis 2013, 66, 2015b, 6, 155).

While Catholic doctrine on sex and marriage has not significantly changed, Pope Francis, has brought a new discussion of mercy and grace to his papacy. In *Amoris Laetitia*, when reflecting on the difficulties many people face in marriage and family life he states:

> We have long thought that simply by stressing doctrinal, bioethical and moral issues, without encouraging openness to grace, we were providing sufficient support to families, strengthening the marriage bond and giving meaning to marital life (Pope Francis 2016, p37).
>
> Rather than offering the healing power of grace and the light of the Gospel message, some would “indoctrinate” that message, turning it into “dead stones to be hurled at others” (Pope Francis 2016, 49).
>
> Hence it is can no longer simply be said that all those in any “irregular” situation are living in a state of mortal sin and are deprived of sanctifying grace (Pope Francis 2016, 301).

The distinction between nature and grace is a debate of historical significance, dating back to the Church Fathers and an important debate both within Catholicism and more broadly within Christianity (Ormerod 2014, VanDrunen 2014).

This thesis suggests that grace is an important conceptual framework underpinning a broad religious discourse on HIV and as such is discussed in more depth in Chapter 7. It is important to note, however, that grace is also important within the traditional religious discourse. Mindful that chapters 5 and 7 describe two ends of a religious spectrum of opinion, which includes considerable areas of overlap, brief reference to the discussion of grace in the context of natural law theory is important to highlight here.

5.4.2 Jesus Christ and the order of grace

Chapter 5 of IUSE discusses ‘the distinction between the order of creation and the order of grace, to which faith in Christ gives access’. The ITC is clear that, ‘Grace does not destroy nature but heals, strengthens, and leads it to its full realization’. Jesus Christ is the fulfilment of NL. God has a plan for salvation, which is realized by Jesus Christ, who came to the world as the living representation of God himself the ‘word made flesh’ the *Logos* (International Theological Commission 2009, 101).

Whilst sin has distorted the image of God in human beings, it is restored in Jesus. He is ‘The image of the invisible God’ (Col 1:15). Jesus lived a life without sin, and therefore conformed to NL. Jesus, in abiding by the Decalogue said he came not to ‘abolish but to fulfil’ the law (Matthew 5:17). By this, the apostle Paul explains in Romans, that Jesus is the *telos* of the law, *telos* meaning both its purpose or goal and its end. His fulfilment of the law comes through his perfect obedience, and love, in that he was obedient in loving people until the end of his life, accepting suffering in his death on the Cross in the place of sinners and opening up for them eternal life (International Theological Commission 2009, 109).

God recognized that people were unable to live up to his law. Therefore, he gave his Holy Spirit to people. The Holy Spirit is the third person of the Holy Trinity, given to those who have faith in Christ. He gives them new power to live as God requires, thus fulfilling the prophecy of Ezekiel: ‘A new heart I will give you, and a new spirit I will put within you; and I will take out of your flesh the heart of stone and give you a heart of flesh. And I will put my spirit within you and cause you to walk in my statutes and be careful to observe my ordinances’ (Ezek 36: 26-27).

5.4.3 Linkages between natural law and human rights

As already noted, the Catholic Church at the UN presents only one end of a very broad Catholic discourse on NL, gender and human rights. There are ongoing debates and discussions within Catholicsm, supportive of NL and human rights, which include critical debate of the Vatican’s conservative stance on sex and

gender. Lisa Sowle Cahill provides a Catholic voice demonstrating something of this discourse. Her work as a feminist Catholic theologian who is supportive of both NL and human rights and gender is illustrative of the much broader debate on these issues (Cahill 1980) (Cahill 2006).

In her essay in *Searching for a Universal Ethic*, she commends the ITC for its targeted and prophetic response to the need for a renewed articulation of natural law in support of the planet and its resources, of global solidarity in the face of wars and conflicts, and of poverty and oppression. She argues that it opens up room for a pluralistic conversation and in NL provides a basis to evaluate evil and inequalities (Cahill 2014, 239). She highlights that NL has limitations, but is a valuable ethical approach. It is stronger in its moral reasoning on issues of social justice than sexual ethics, where she demonstrates evidence of 'bias, disagreement and even oppression'(Cahill 2014, 240). She challenges the Church to engage in the public space of religion and politics to bring compassion, and justice but to avoid rigid presentations of moral and ethical teaching (Cahill 2014, 243, 244).

Cahill argues that understandings of the 'nature' and status of women have changed over time, apart from the 'obvious constant' of physiological reproductive capacity. Thomas Aquinas viewed women as weaker and less rational than men, requiring male control. The Popes' views on women have also changed over time: Pope Pius XI in 1930 said that women should be subject to their husbands, and not given management over financial affairs. Pope John Paul II by contrast praised the 'great process of women's liberation' in the context of a modern world changing its reading of religious traditions and a growing theological defence of gender equality (Cahill 2014, 246). Cahill explains that whilst the ITC affirms equality, it does not recognize that disputes surrounding equality and equal treatment go deeper than the theoretical discourse, and are about wealth, goods and power. She makes three key points. First, if the Catholic Church is to establish that the sexes are equal, then consensus is needed on what that means in practice and in order to arrive at that consensus a process of participatory negotiation is required. Second, Catholic social teaching on NL does not adequately account for the 'staying power of injustice' and is overly confident that evil can be overcome by goodwill. Whilst readings of

Augustine provide a counterpoint to the optimistic narrative of Thomistic natural law, these do not go far enough. And third, it is not possible to ignore the partiality and also the 'wilful, if self-deceived bias' of the past in access to human goods (Cahill 2014, 246, 247). These perspectives present an important counterpoint to those of Adolphe, and others which dominate religious discourse on women at the UN and are explained in more depth in annex 5.

5.4.3.1 Protestant theological perspectives on natural law and human rights.

Protestants have a similar interpretation of human dignity to Catholics, both stress the importance of:

i) human dignity as a fundamental principle underpinning human rights, emanating from man being made in the image of God;
ii) a person's duty to worship God, including the idea that this freedom should be respected by both society and the state, and
iii) the communal nature of human living and therefore rights cannot be individualistic, but are to be realised in community (Shupack 1993, 129, 149).

Protestants share the Catholic understanding that man is given guardianship over the earth and has rights to basic subsistence and the means of production. They agree that God's image is reflected in His created people, both men and women, and that the image of God is reflected in human nature in its totality, not simply as spiritual beings. People are therefore entitled to social, political, cultural, economic rights and protection of freedom of religion, belief, association and worship (Shupack 1993, 150).

Protestants however, emphasize the doctrine of salvation by grace in their human rights theology, over considerations of NL. Renewed Protestant debates around the concepts of NL and grace are discussed by Daryl Charles, John Witte and Justin Latterell and David VanDrunen. Charles provides an overview this engagement in the NL debate, challenging the view that Protestant theology is not compatible with natural law theory.

He documents how NL is central to the teaching of both Luther and Calvin (Charles 2006, 3, 4), and how Karl Barth expressed concern that the Catholic interpretation of natural law starts from the premise that man is essentially

good and thus does not take sin seriously enough. Protestant theology emphasizes humanity's sinful nature, which is redeemed by Christ. John Yoder and Stanley Hauerwas both reject the Catholic emphasis on NL, challenging the assertion that NL and grace do not oppose one another. Yoder argues that the focus on NL in a sinful and fallen world opens the potential for 'national idolatry and patriarchy'. Hauerwas discusses the 'false dualism' between NL and grace, which is not evident in 'historic Christian Theology' (Charles 2006, 7, 9). Charles concludes that:

> At the heart of the rejection of natural law by Protestant social ethics is the erection of a false dichotomy between nature and grace, leading to the mistaken assumption, particularly among evangelical Protestants, that the natural law is distinct from "Christian social ethics." This mistaken distinction fails to see the role our common human nature plays in moral theory and moral discourse—and thus it undermines any attempts to enter the public square, where critical ethical issues are at stake (Charles 2006, 9).

Charles makes the important observation that: 'Protestant theology generally mirrored the Enlightenment culture around it' (Charles 2006, 6), which left much of the public debate around the intersection of NL, theology and human rights to the Catholic Church. Witte and Latterell describe the historical intersections of the enlightenment and Protestant concepts of human dignity and NL.

> Human rights were the mighty new weapons forged by American and French revolutionaries who fought in the name of political democracy, personal autonomy, and religious freedom against outmoded Christian conceptions of absolute monarchy, aristocratic privilege, and religious establishment (Witte and Latterell 2015, 357).

Christianity was an important element in the development of Western human rights thinking and law. Theologians from both Catholic and Protestant traditions have expressed reservations about Human Rights and the dangers of Enlightenment liberalism, individualism and rampant secularism all challenging the status quo. There was nevertheless an important religious element in the

revolutionary movements seeking to retain a Christian faith free from the control of Catholic Church establishment.

So, whilst the Papal Revolution of the 12th Century called for freedom of the Roman Catholic Church from state intervention, the revolutions of 16th Century Protestant Reformation were about freedom from the control of both Church and the Monarchy (Witte and Latterell 2015, 369). The Protestant reformers were influential in their 'efforts to define the nature and authority of the family, the church, and the state vis-à-vis each other and their subjects' (Witte and Latterell 2015, 370). This history of separation of Church and State is very important to this thesis. The Catholic Church insistence on freedom from state intervention in their worship, governance and hierarchy, led, in some countries to the Church being able to control individual freedom of belief, worship, and exert huge social control. The Protestant call for separation of church and state was initially intended to protect the individual's freedom of thought, belief and worship from the Catholic Church. These differences and tensions from the revolutions of the 12th and 16th Century have played out through history and directly impact negotiations at the UN today.

At the UN Human Rights Council, in conflicts around religious freedom, the Catholic and Russian Orthodox Churches continue to argue for religion itself to be protected, whereas the Human Rights Council considers freedom of religion and belief to belong to an individual (see annex 5). This is a remnant of Protestant influence on secular human rights law from the Reformation and is important to this thesis because one of my arguments is that debates about religion at the UN have become increasingly polarized with the marginalisation/withdrawal of Protestant and other religious voices from the debate.

David VanDrunen provides an extensive and detailed theology of NL from a Reformed Protestant perspective based on rigorous Biblical analysis. He agrees with the traditional Reformed notion that there is one single organically unified covenant of grace through biblical history- mediated through a series of covenants (VanDrunen 2014, 12).

VanDrunen does not attempt to provide a strategy for including a protestant theology of natural law into the public sphere but does provide a substantial and well researched theological case for the continuum of God's covenants, including natural law and grace based on Reformed theology, grounded in Biblical exegesis.

Annex 5 takes the discussion on development and debates further. It provides additional information on how the conceptual frameworks outlined in this section, including the theological understandings of NL and human rights, have been interpreted by supporters of a conservative religious perspective and applied to the issues of SRHR and HIV at the UN.

5.5 Supporters and Strategies

5.5.1 The privileged position of the Holy See at the UN

The Holy See has been recognized as a permanent observer state within the UN system since 1964 (Stensvold 2016b, 96). Observer states can participate in negotiations on the same terms as Member States, but cannot vote in the GA (Stensvold 2016b, 96). Other religious organizations, including the Russian Orthodox Church and the Organization of Islamic Conference, do not have this privileged position, which gives the Holy See access to the preparation and negotiation of documents and to resolutions, as well as the opportunity to make formal statements to international conventions (Stensvold 2016b, 96). For this reason, whilst there is a broad range of actors supportive of the traditional religio-cultural discourse, the Holy See enjoys a more influential role in debating issues and lobbying. In practice, the Holy See frames an issue in the UN debates on HIV and gender from the perspective of supporters of the traditional religio-cultural discourse, and other actors (including Member States) take up the framing and use it in their negotiations.

There have been papal ambassadors (*nuncios*) in the diplomatic corps in Catholic countries since 1815; this was rapidly scaled up after the Second Vatican Council (1962-1965) when the decision was made by the Vatican 'to engage more actively with the world'. Pope John Paul II increased the number of *nuncios* from

84 to 178 between 1978 and 2002. This provides the Vatican with close relationships, information and possible influence in 178 countries, and the opportunity to forge alliances at national level on issues of international importance (Stensvold 2016b, 97). In 1957 the Vatican changed its name at the UN to the Holy See. This change is significant because Vatican State has a very small population of approximately 600 people, but the Holy See represents Catholic Churches world-wide. The Holy See has used this dual identity in different ways on a variety of issues.

This chapter and the accompanying information in annex 5 has demonstrated the leadership role taken by the Catholic Church in articulating the traditional religio-cultural discourse on human rights, marriage and family, parents, women and girls, children, HIV and SRH. Specifically it has shown how it has articulated its own teaching to align with, and according to Stensvold, to appropriate the UDHR (Stensvold 2016b, 103).

Representatives of the Holy See to the UN make statements regularly on these issues and use the opportunity to put forward the traditional religio-cultural framing, which is then taken up by MS in their interventions. For example: in 2011, the intervention on the Declaration of Commitment on HIV & AIDS given by the Holy See defines marriage according to the Catholic Church definition, as restricted to one man and one woman, and states that this must be acknowledged by MS. It links the statement to UDHR Article 16.3,[11] which is the Article on families, not on marriage.

> States must acknowledge that the family, based on marriage being the equal partnership between one man and one woman and the natural and fundamental group unit of society, is indispensable in the fight against HIV and AIDS, for the family is where children learn moral values to help them live in a responsible manner and where the greater part of care and

[11] The family is the natural and fundamental group unit of society and is entitled to protection by society and the State (General Assembly Resolution 1948, 16.3).

> support is provided (cf., Universal Declaration of Human Rights, Article 16,3) (Holy See 2011).

The article on marriage (Article 16.1) does not specify one man and one woman, but is broader, mentioning men and women.

> Men and women of full age, without any limitation due to race, nationality or religion, have the right to marry and to found a family. They are entitled to equal rights as to marriage, during marriage and at its dissolution (General Assembly Resolution 1948, 16.1).

Critics of the Holy See's privileged position at the UN highlight this strategy of carefully crafted and nuanced re-interpretation of the UDHR and repetition of the traditional religio-cultural framing at the UN. This, combined with the Holy See's access to governments at ambassadorial level in 178 countries that have diplomatic missions in New York, is regarded by critics as a major challenge to the public health, human rights and gender equality discourses in public policy on HIV and SRHR at the UN.

Popes have also played a significant and direct role in both articulating and influencing this discourse. Further explanation of how they have used this influence is in annex 5.

5.5.1.1 Interventions of the Holy See at the UN

It is important to repeat here that there are many areas of consensus between secular human rights law and Roman Catholic articulation of NL, and on these issues the interventions of the Holy See at the UN are broadly aligned and supportive of human rights, gender equality and scientific evidence. The Catholic Church frequently cites NL and elements of Catholic social teaching as a basis for these interventions. There are also significant differences however, as this chapter has explained, and these differences can result in tension and conflict in negotiations at the UN. The Holy See also uses NL to support its interventions on contentious issues such as, women's rights, LGBTI rights,

abortion and end of life issues. This tension is also evident in negotiations on HIV and AIDS and discussed further in annex 5.

The following section provides a clear example of where there is consensus between the two sets of conceptual frameworks. Over many years the Holy See has mounted a consistent and well researched campaign, to scale up the development of affordable, accessible and palatable HIV medications for children. They have strategically used their position at the UN to take this forward in a range of different settings, with advocacy that is based on both human rights and Catholic social teaching and natural law. This is an area of synergy between Catholic and secular health actors and strong working relationships and collaboration have led to tangible positive results.

Archbishop Silvano Tomasi, Papal Nuncio and Permanent Observer to the Holy See in Geneva published a collection of all interventions by the Holy See in Geneva during the ten years of his tenure. He documents the series of interventions on access to medicines for children presented at the Human Rights Council, the World Health Assembly, and the World Trade organization between 2010 and 2015. Themes in these interventions include a challenge to the global community to invest in 'research, treatment, vaccination and prevention education respectful of the natural moral law; the call for a fair distribution of resources for research and treatment based on social justice; perspectives on 'health security grounded on an anthropology respectful of the human person' (Tomasi 2017, 615, 616); challenges to pharmaceutical companies to address intellectual property complexities in line with ethical perspectives based on the dignity of the human person; a challenge to the Special Rapporteur on Human Rights to look beyond legal frameworks to consider solidarity and social and political factors which deprive people of access to medications (Tomasi 2017, 642, 648); the primacy of the right to health over a focus on profit, calling on the pharmaceutical companies to strive towards 'child-sized', fixed-dose combinations, of acceptable taste and form, and easy to administer to infants and very young children' (Tomasi 2017, 654).

These interventions are carefully crafted to include scientific facts, analysis of the respective reports from UNAIDS, the WHO and the Special Rapporteurs and reflect an accurate understanding of the complexities of international trade and

TRIPS agreements as well as the difficulties involved in developing paediatric medications for HIV in children. Pope Francis himself supported this campaign in his address to the US Congress in 2015 (Tomasi 2017, 660), in *Amoris Laetitia* (Pope Francis 2016, 35) and in his message to the 32nd Vatican Health Conference, '*Addressing global health inequalities*' (Francis 2017) with a specific message for representatives of pharmaceutical companies gathered in a parallel consultation to address access to paediatric medicines for HIV.

This longstanding international advocacy culminated in 2016 and 2017 with a series of consultations to address the challenges of scaling up access to paediatric medications for HIV facilitated by Caritas Internationalis and hosted by Cardinal Turkson at the Vatican Academy of Sciences, to bring together representatives of pharmaceutical companies, people living with HIV, faith-based health service professionals, UN and other scientific experts and bilateral donors. Tangible outcomes from these consultations include tighter targets for access to HIV medication for children, included in the 2016 Political Declaration on HIV & AIDS, and a 41-point action plan to address bottlenecks and challenges to achieving these targets.[12]

This section demonstrates that collaboration between the UN, Member States, the Holy See and faith-based partners can be extremely successful and benefit from some of the principles of Catholic Social teaching and its foundations in NL where there is consensus between these conceptual frameworks and those underpinning Human Rights, Gender Equality and Scientific evidence.

5.5.2 Roles played by Member States

Negotiations on the text of PDs are confidential, but through the public statements of support or reservation made by MS at the closing and adoption of a resolution, their positions are clear. Reservations expressed by MS at the close of the Beijing conference in 1995 refer to, and support, all the main elements of the traditional discourse. The first two interventions from MS, representing majority Catholic and Muslim faiths respectively, repeat the majority of issues

[12] http://www.pedaids.org/wp-content/uploads/2018/02/Rome_Action_Plan_2017.pdf

characteristic of the traditional discourse outlined in this chapter, and link them to national sovereignty. The second quotation is included in full in annex 5 to demonstrate the detail with which MS respond to the documents, and the level of agreement between the positions of these MS and the framing of the traditional religio-cultural discourse as set out in this chapter.

> The concept of family as used in the Conference documents is understood (*by this delegation*) to mean the union of a man and a woman, who produce, nourish and educate their children. Argentina (United Nations 1995a, 154).

> No definition or recommendation contained in these documents weakens the parents' primary responsibility for bringing up their children, including providing education on sexual matters, a responsibility which should be respected by States pursuant to the Convention on the Rights of the Child. Argentina (United Nations 1995a, 154).

The representative of Brunei Darussalam submitted the following written Statement (United Nations 1995a, 154-5):

> We have the honour to officially inform you in writing that there are certain paragraphs in the Platform for Action adopted at the plenary of the Fourth World Conference on Women on 15 September 1995 that are contrary to Islamic principles and that are therefore not acceptable to Brunei Darussalam. (United Nations 1995a, 154-175). (See annex 5)

The Holy See gave an extensive written statement carefully re-affirming key elements of the traditional framing and making a link to national sovereignty through reference to 'colonization' of the rights discourse by a libertarian agenda (United Nations 1995a, 159).

> My delegation regrets to note in the text an exaggerated individualism, in which key, relevant, provisions of the Universal Declaration of Human Rights are slighted - for example, the obligation to provide "special care

> and assistance" to motherhood. This selectivity thus marks another step in the colonization of the broad and rich discourse of universal rights by an impoverished, libertarian rights dialect. Surely this international gathering could have done more for women and girls than to leave them alone with their rights!

Annex 5 takes the discussion of strategies and supporters further and provides additional information on how supporters of this position, including the Russian Orthodox Church and the Organization of Islamic Conference have developed strategies together to advance this position on SRHR and HIV at the UN.

5.6 Conclusions

Some of the elements of the traditional religio-cultural discourse are enshrined in the UDHR. For example; every person has inherent dignity and entitlement to human rights, the family unit is central to society, and should be respected and protected, parents play a critically important role in educating their children, and individuals should have the freedom to practice a religion of their choice. There is consensus across all stakeholders on these fundamental human rights. Conflict arises around how these are interpreted and applied.

One central problem is that the traditional religio-cultural discourse proponents claim that their moral teachings on family and their own NL framing of concepts apply to everyone, not just religious adherents. This interpretation applies the ‘natural law’ theory to fundamental human rights and claims direct linkages between God, human dignity, human rights, individual responsibilities and duties. Stensvold refers to this as ‘appropriation’ of the fundamental principles of human rights (Stensvold 2016b, 103).

Through this strategy the traditional religio-cultural discourse supporters have ‘taken ownership’ of the interpretation of some fundamental human rights, and the concept of family (Moe, Stensvold, and Vik. 2014, 1).

When the ‘natural law’ theory is put forward as a non-negotiable ‘given’ applicable to all, then the discourse is operating as an ‘oppressive ideology’, ‘impermeable to evidence and argument’ (Freeden 2006, 6).

The Holy See has a unique position at the UN and generally leads in the framing and articulation of traditional religio-cultural discourse in the negotiations and provides text to the draft declarations. MS from different geographical regions and majority faith traditions take up elements of the traditional religio-cultural discourse articulated by the Holy See and put them forward during the negotiations.

Chapter 6. Political discourses at the UN

6.1 Introduction, key words, research questions

This chapter and the accompanying annex 6 discuss the complex set of inter-relationships between politics, nationalism, national sovereignty, secularism and religion. These interactions occur both within individual states and between MS in their negotiations at the UN. A simplistic binary representation of ‘secular states’ and ‘religious states’ fails to capture this complexity. The chapter builds on the discussion in chapter 5, which highlighted some of the ways in which the traditional religio-cultural and the national sovereignty discourses work together to put forward an agenda at the UN on HIV and SRH.

Several parallel political discourses operate at the UN in policy-making on HIV and SRHR. In line with the principles and practice of interdisciplinary research, this chapter outlines the main themes within these discourses, the concepts and theories that support them, how the issues are framed, and some of the important debates, with the aim of analysing how they influence the Political Declarations (PDs) on HIV & AIDS negotiated at the UN.

Three themes are discussed in this chapter: i) HIV as a political issue that requires strong political leadership; ii) national sovereignty; iii) the influence of secularism - at the UN, within some MS, and within sectors (such as public health and international development) involved in the HIV response.

Political discourses interact with religious discourses in a variety of ways. Most, if not all, countries have citizens who are religiously affiliated. Even where there is separation of religion and state, religion can be influential, especially around issues of family, gender roles, sex and sexuality and parenting of children. Religious teachings can impact on national policy and legislation on these issues. Similarly, religion can influence policy, programming and funding when MS discuss HIV and SRHR at the UN.

Key words and phrases associated with the political leadership, ownership and commitment discourse in the PDs on HIV & AIDS:

Heads of state; government; political; national; representatives; member states; region; alignment; mutual accountability; our respective societies; their own responses; responsibility, political leaders, parliaments, sub-regional organizations; national strategies; South-South/ South-North and triangular collaboration; national ownership and leadership; shared responsibility; declaration of commitment; commit; solemnly declare; redouble efforts; reaffirm determination; grave concern.

Key words and phrases associated with the national sovereignty discourse in the PDs on HIV & AIDS include:

National laws; national development priorities; sovereign rights; distinctive; each country's epidemic; uniquely tailored to each particular situation; each country concerned; nationally driven; define the specific populations key to its epidemic and response; national context; peculiarities of each country; country-led transparent process; giving consideration as appropriate; in accordance with national legislation; local circumstances; as deemed appropriate; encourage member states to consider; relevant national frameworks.

This chapter will seek to address the following questions:

- What are the main elements of the political leadership and national sovereignty discourses on HIV and SRHR at the UN?
- What are secularization and secularism?
- How do secularization and secularism influence political and religious discourses and policy-making on HIV and SRHR at the UN?
- What types of interaction between religion and state can be observed at national level relevant to HIV and SRHR?
- What types of interaction between religion and state can be seen in operation at the UN?

6.2 Framing the discourses

6.2.1 Main elements of the political leadership discourse on HIV and SRHR at the UN

HIV is a political issue and political leadership is important in the HIV response. The complexity of the HIV epidemic, which has no vaccine or cure, demands a robust political response. This is the case for a variety of reasons. Public health risks associated with HIV pose a threat to national economies and national security when many adults are affected and cannot work without treatment. Social and gender inequalities, which exacerbate the epidemic, require changes in social norms through education, community engagement and smart use of the media. Human rights failures identified in chapter 3 may require states to enact changes in legislation. An effective public health response to the epidemic may require changes in legislation and public policy, such that funding is targeted towards effective interventions (Schwartländer et al. 2011) (Smith 2013).

Political leadership in the HIV response has been unprecedented in the public health field. As this response unfolded in the 1990s, political mobilization led to the first High Level Meeting of the United Nations General Assembly on a disease in 2001. The outcome was the *Declaration of Commitment on HIV/AIDS* (General Assembly Resolution 2001). Subsequent Political Declarations on HIV & AIDS in 2006, 2011 and 2016 reinforce the fact that HIV is a political issue of significance at the UN (Smith 2013). Political leadership remains vitally important to meet the funding needs of the epidemic at global and national levels, given the competing needs for resources. The HIV response requires an annual investment of US$ 7.4 billion in 2020 in low-income countries and US$ 10 billion in lower-middle-income countries to meet the goals of the PD2016 (UNAIDS 2015c, 67-68).[13]

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[13] By 2020, annual international HIV assistance should reach at least US$ 12.7 billion (or 40 percent of the resource needs for low- and middle-income countries) 'To achieve financial targets by 2020, governments of low-income countries will likely need to fund 12 percent of their total resource needs for HIV, lower-middle-income countries 45 percent and upper-middle-countries 95 percent'(UNAIDS 2015c, 67-68).

Forward-looking political leadership has been the hallmark of the HIV response. It challenges the status quo, is prepared to push forward the agenda, is honest in naming those most at risk, basing responses on human rights and dignity and striving to find innovative ways to reach those most in need with services and education. It is visionary, takes responsibility, makes and fulfils commitments-especially financial commitments, is accountable, inclusive and collaborative. This kind of leadership has enabled the HIV response to reach the target of 15 million people on antiretroviral treatment nine months ahead of the target dateand will be required to end AIDS as a public health threat by 2030 (UNAIDS 2015b, 160).

6.2.2 Main elements of the national sovereignty discourse on HIV and SRHR at the UN

There is another kind of political leadership evident in the HIV response, which promotes national sovereignty and is characterized by fear and reticence. The key words and phrases characterizing this, which are found in the PDs on HIV & AIDS, are limiting, restrictive, tentative and guarded in nature. As discussed in chapter 5, this discourse has its origins in resistance to colonialism and is suspicious of human rights as Western impositions, which are perceived to limit or restrict a country's self-determination and autonomy, culture and religion (Beattie 2014, 5). These fears and historical linkages have been exploited by supporters of the traditional religio-cultural discourse to build broad alliances of unlikely partners to advance the traditional religio-cultural discourse at the UN (Moe, Stensvold, and Vik. 2014, 12). Chapters 8 and 9 will argue that the national sovereignty discourse has compromised and limited the text of PDs on HIV prevention, women and girls, and hampered attempts to identify and reach key populations most at risk of HIV infection with combination HIV information and services.

6.3 Conceptual Frameworks

A third political discourse at the UN is secularism. It does not appear in the PDs on HIV & AIDS, but as this chapter and the analysis in chapter 10 will discuss, has a significant influence on the content of the PDs.

6.3.1 Understanding secularization and secularism

According to Grace Davie and Linda Woodhead, secularization is descriptive of the processes by which; i) religious institutions decline; ii) religion declines in importance for society; and iii) religious importance declines for individuals. Secularization theories attempt to explain secularization. 'Hard' versions of secularization theory consider modernity and religion to be mutually incompatible; as a society modernizes, secularization is inevitable. 'Softer' versions of secularization theory recognize the links between modernization and secularization but do not claim that secularization is inevitable (Woodhead and Davie 2016, 524). Desecularization is a term used to describe processes involving 'the resurgence of religion and its societal influences in reaction to secularization' (Karpov 2010, 236).

6.3.2 Secularism as an ideology

Secularism can operate as an oppressive ideology, which actively opposes religion as inherently bad. Some of its proponents, such as Richard Dawkins, argue that religion should be removed from all three domains of life: state, public and private. Others subscribe to 'political secularism', which is confined to removing religion from the state and political institutions (Woodhead and Davie 2016, 525).

Woodhead and Catto make two observations of importance to this thesis. Firstly, that the vehement defence of secularism by its proponents confirms that it is an ideology, counter to religion, which must be defended:

> Like religion, it makes alliances with power. And like religion it has its charismatic figures, prophets, elites, holy books, and heretics. So theories of secularization, bound up with secular commitments may be just as

> value-laden and passionately held as theories of de-secularization (Woodhead and Catto 2013, 4).
>
> Secularization is now so established that it has shaped the entire field: how agendas are set, research questions asked, survey questions framed, data collected and analysed. Even theories of de-secularization are framed in its image (Woodhead and Catto 2013, 3).

Woodhead makes the point that secularism is an ideology, not a theory, as the assumptions and concepts of theories are supported by evidence (Woodhead and Catto 2013, 4).

6.3.3 Understanding Ideology.

At this point it is worth exploring ideology within the context of this conceptual framework. Ideology is a subject of debate within political theory with a long history. Michael Freeden describes ideology, or more accurately, diverse ideologies, in several ways, as: ‘an all-encompassing system of political ideas based on a single truth’, ‘diverse forms of substantive concrete configurations of political ideas’, ‘thought products of the political sphere’ and as ‘human and social products that bind together views of the world’ (Freeden 2006, 4, 6, 14, 20). He points out that whilst ideologies are inherently linked to power dynamics, they are not always oppressive, but a reflection of collectively produced societal understanding and are both ‘inevitable’ and ‘ubiquitous’ (Freeden 2006, 4, 14, 19, 20).

Both Michael Freeden and Fred Eidlin discuss the historical roots of ideology, which along with secularism took shape during the movements of the Enlightenment and French Revolution, ‘the enlightenment philosopher- Antoine Destutt de Tracy (1754-1836) coined the term as the name for his new science of ideas’ (Eidlin 2014, 1). For Karl Marx (1818-1883) ideology was more of a dichotomy between truth and falsehood: ideology was ‘deductive, rationalistic and non-empirical, a state of ‘dogmatic impermeability both to evidence and to argument’ (Freeden 2006, 6). The post-war philosopher Karl Mannheim (1893-1947) introduced more pluralistic thinking to the debate, with the idea that

practices and understanding could change over time. As indeterminability became more acceptable over time, ideologies were used to make sense of complexity and give a sense of belonging. Ideologies can be linked to powerful leaders or movements who can exploit them for political ends, and in times of war and crisis people are more susceptible to extreme ideologies (Freeden 2006, 11) (Eidlin 2014, 3, 4). Some authors suggest that ideology is confined to the political sphere, and that political thought itself can be ideology, others recognize shared characteristics between religion, political ideology and science. Eidlin identifies the earliest roots of ideology in ancient Greek philosophy and texts of the Judeo-Christian religions (Eidlin 2014, 6) (Freeden 2006, 13). These observations are important for this thesis as natural law theory has origins in ancient philosophy and religious texts and this thesis will argue that both religion and secularism can be used as dogmatic, 'oppressive ideologies, impermeable to evidence and argument', but can also operate in other more constructive ways (Freeden 2006, 6).

John Gerring provides an extensive review of attempts to define ideology noting the complexity of the field and pointing out that within the different approaches to definition there are many contradictions. Gerring provides seven domains or definitional categories, broken down into 33 sub-categories (Gerring 1997, 966). Some authors advocate abandoning the term altogether as it is so complex, and contradictory. He argues rather, that as it is so entrenched in social science that a systematic framework for its definition is helpful. Jasmine Gani, nearly 20 years later, reviews the place of ideology in current critical theory and refers to Raymond Geuss of the Frankfurt school, who also recognized its complexity, and identified three approaches to ideology; a pejorative perspective, a positive viewpoint and a more neutral, descriptive approach (Gani 2016, 2). Gani then outlines a seven-point typology of ideology, which includes: 'a set of normative and explanatory beliefs' for society and politics. These 'express human agency and intent' and can be used to maintain 'the status quo- as is the case with conservatism', or alternatively as a 'vehicle for change'. 'Ideologies usually purport to offer a 'morally correct' set of values, such as justice through equal distribution of wealth….or human rights through democratisation; thus altruism is often a core justification'(Gani 2016, 3). Reason, she observes, can have a

dual function, both to support the rational-choice theory of individualism within a liberal tradition, and to support the development of moralism within political theory. When ideologies are presented as ‘universal messages’ and embedded in structures to support state or other systems, they tend to reject pluralistic interpretations and cast any challenge to the ideology as a threat to ‘stability and order’ (Gani 2016, 4). Whilst ideologies tend to be universalizing there are nevertheless internal narratives and debates, they are not timeless and do change over time. One method of change occurs with the shifting of concepts from the ‘core to the periphery’ of an ideology and vice-versa (Freeden 2006, 16) (Gani 2016, 5). Finally, ideologies operate beyond the political sphere, including in social and cultural domains.

Gani’s analysis indicates that ideologies can be used to support both conservative and liberal political and social agendas, which is important to this thesis. I argue that both the traditional religious discourse and hard secularism operate as polarizing ideologies at the UN, but that this need not be the case. Gani points out that there is a place for ‘analysts of ideological agency to overcome the impasse, and to some extent false binary, between idealism and pragmatism’ (Gani 2016, 4).

Taking together these ideas about how one group or another creates rules and hegemony to exert social control and maintain their position of power: I would argue that both the natural law theory of the Catholic Church (NLCC) and hard secularism are operating as ‘oppressive ideologies’ in the policy-making discourse on HIV and SRHR at the UN. Chapters 8 and 9 will revisit this discussion.

6.4 Development and debates

How do secularization and secularism influence political and religious discourses and policy-making on HIV and SRHR at the UN?

6.4.1 The influence of secularization and secularism on political and religious discourses and policy-making on HIV and SRHR at the UN

Secularism has been the dominant paradigm in politics, diplomacy, science and human rights in Western Europe and the USA since the establishment of the UN. (Marshall 2017a, 20-21). Several authors have documented the rise and influence of secularism on health and development, which started around the time of the Enlightenment, reflecting processes of secularization that were taking place in industrialized nations, and gained strength along with the concepts of modernity and progress. Based on the idea that religion is irrational therefore incompatible with the natural, social and political sciences, an increasing bias against religion developed over time. Through the 1940s-60s, as medical science gained in strength, and the successes of clean water, vaccination, and other public health measures demonstrated results in the health of populations, science became seen as the answer to 'the problem', whatever the problem. Religion was constructed as the binary opposite of science, with nothing substantive to offer. In a few decades, longstanding collaboration between national governments and faith-based health service providers diminished. Faith-based institutions became almost invisible and lost valuable connections with national and global health service systems (Olivier 2010, 39, Stensvold 2016a, 2, Marshall 2017a, 21, Copson 2017).

Secularism as the dominant ideology was blind to these consequences. Alasdair and Joey Ager identify three consequences of hard secularism: the privatization, marginalization and instrumentalization of religion. Religion was relegated to the private domain and strong taboos imposed on bringing it into professional, public or political life. This reinforced its invisibility in the medical and public health fields (Olivier 2010, 31, Ager and Ager 2016, 102).

Given the exclusionary effects of secularism, Ager and Ager ask two critical questions: is secularism a feasible strategy to manage plurality given that secularism in its current form marginalizes some of the partners crucial to the goals of sustainable development? Second, is marginalizing plural voices a greater threat to stability and security than their deliberate and open inclusion?

(Ager and Ager 2016, 2-4). I argue in this thesis that the systematic silencing of the plurality of religious voices from political, health and development fields for five decades is a serious concern that has opened space for strident voices, which put forward a narrow and divisive religious agenda on HIV and SRHR. This, in turn has fuelled further entrenchment of a hard secularist position, thus exacerbating the tensions and further polarizing the debate.

6.4.2 Interaction between religion and state at national level relevant to HIV and SRHR

This section explores different types of interaction between religion and state in national contexts. These relationships influence how the MS responds to religion at the UN.

Katherine Marshall comments that:

> Notwithstanding common and over-simplified notions that secularism means simply the exclusion of religious matters from affairs of state, in reality many very different understandings and arrangements govern relations between states and religious institutions (Marshall 2017a, 20).

France, is an example of 'hard secularism', which dominates official political and public practice (Woodhead and Davie 2016, 524). Other states, such as the United Kingdom and Norway, practice a form of 'twin tolerations' (Stepan 2000, Stepan 2001, Razavi and Jenichen 2010, Vik and Endrensen 2017). Religious individuals and institutions have no privileged prerogatives to mandate public policy to democratically elected governments, but are free to worship and to promote values and activities in civil society provided these do not violate law or impinge upon the liberties of others (Stepan 2000, 39).

Ingrid Vik and Cecilie Endrensen provide a history of the development of church-state relations in Norway, where faith and state have existed side-by-side (Vik and Endrensen 2017). Religion is considered a personal and private issue in Norwegian politics and foreign policy. Additional analysis by Endrensen and Vik,

and separately by Arne Olav Øyhus, demonstrates that Norway has worked closely with religious NGOs in relief and development both nationally and through international development aid, specifically on issues of HIV and SRHR. Norway is one of the strongest advocates for HIV and SRHR at the UN and has funded important work on religion and SRHR through faith-based organizations (FBOs) and UNFPA (UNFPA 2016, Paterson and Long 2016). Religion is firmly separated from state politics and international relations however (Vik and Endrensen 2017, Øyhus 2016). In complex situations of conflict where religious factors influence the crisis, Norwegian diplomats have drawn on FBOs that have an in-depth knowledge of the local religious dynamics. The religious discourse is not considered central to diplomatic work itself, however. Norway would therefore not consider it appropriate to introduce religious issues to negotiations at the UN (Vik and Endresen 2017, 177).

In the USA the interaction is different. Separation of church and state is written into the second amendment of the Constitution. Whilst there is formal institutional separation between faith and state, there are active connections between different forms of religion and political parties, such that religion has significant influence on politics. Ongoing controversy exists between those who argue for a stronger separation of church and state, and others who view Christianity as an integral part of American life that should shape its law and politics (Bernstein 2010, 1025 Woodhead and Davie 2016, 532).

Katherine Marshall provides two examples of the influence of religious groups on public policy on HIV and SRHR under Republican administrations in the USA, which had significant impact in other countries. First, the provision of funding for abstinence-only education in the HIV response, and second, a ban on funding for NGOs that provide information to women on abortion (Marshall 2017b, 133). The latter, known as the ‘Global Gag Rule’, is a policy of the USA that prohibits funding to foreign aid organizations that provide abortion services. The gag rule was first imposed by the Reagan administration in 1984. It was rescinded in 1993 by President Clinton, reinstated in 2001 by President George W. Bush, and rescinded again by President Obama in 2009 (Marshall 2017b, 133, Population Action International 2016).

The current Republican administration reinstated this policy in January 2017. The Centre for Reproductive Rights issued a statement from a Coalition of women's activists opposing this move on the grounds that 'the global gag rule goes further by blocking aid to foreign organizations who use their own non-U.S. funds to provide information, referrals, or services for legal abortion or to advocate for access to abortion services in their own country' (Center for Reproductive Rights 2017). In this example, women's sexual and reproductive health and rights are limited by a funding policy influenced by a conservative Christian doctrine.

Under President George W. Bush, the Christian right lobbied effectively for dedicated funding for abstinence-only education to be a part of the President's Emergency Plan For AIDS Relief (PEPFAR) programmes both at home and overseas.[14] Anthony Petro explains that this was part of a successful campaign by Christian evangelicals in the USA in tandem with the media and conservative politics to articulate the discourse around AIDS in the 1980s as a 'moral proposition' (Petro 2015, 19), i.e., that AIDS is 'a sexual epidemic, and that moral and spiritual healing will be crucial to end it' (Petro 2015, 21).
This discourse began when AIDS was first discovered in the 1980s among gay men. Prominent evangelical leaders made public statements about the connection between homosexual activity as a sin and AIDS as a punishment from God, including punishment on a society that has tolerated homosexuality (Petro 2015, 24). Homosexual people were not 'hapless victims of some strange new biomedical disease. Rather… AIDS was a moral epidemic, complete with a hierarchy of victimhood that placed innocent children above implicitly guilty homosexuals' (Petro 2015, 2).

During the 1990s, Petro explains that the discourse on AIDS among leaders of the mainline denominational churches, some African-American leaders, and the

[14] Recent research demonstrates that there was no demonstrable impact from the investment in abstinence-only programmes on any of the five outcomes indicative of high risk sexual behaviour: i) number of sexual partners in the past twelve months for men ii) and for women, iii) age at first sexual intercourse for men iv) and for women, and v) teenage pregnancies (Lo, Lowe, and Bendavid 2016, 1).

public health community was that the disease should be addressed with comprehensive sexuality education, accurate medical facts, compassion and care. Some evangelical and Catholic approaches, however, focused on ‘changing human moral behaviour to re-align it with a specific pre-determined moral code’. This approach, in line with the traditional religio-cultural discourse, prevailed. AIDS was therefore defined as a ‘moral crisis’ (Petro 2015, 6). Rather than calling on the state to fulfil its duties to meet the needs of its citizens, rhetoric from the religious community and the media turned to ‘cast those needs as anti-American, as a danger to rather than within the state’ (Petro 2015, 9).

These polarized positions characterized the first decade of the response to AIDS in the USA: the nation was under siege and the only way to protect it was to adopt the moral teaching of the church, to adopt specific norms about sexual relationships, and to protect the traditional family. In this context ‘the moral proposition includes abstinence before marriage and fidelity within it; hence the political and religious powers were in alignment, so that funding for abstinence only education programmes were secured within PEPFAR’ (Petro 2015, 19). Petro’s analysis shows how the position taken by Christian activists in the USA to articulate HIV as a ‘moral proposition’, defined the discourse in ways that were divisive. It undermined broader religious discourse on HIV and led to policies that restricted comprehensive sexuality education and public health measures for more than a decade. This is an example of a traditional or conservative religious discourse operating as an oppressive ideology casting liberal social changes as a threat to morality, ‘stability and order’ and effectively marginalizing the other religious voices seeking closer alignment with scientific evidence, compassion and comprehensive education (Gani 2016, 4).

See annex 6 for additional examples of interaction between faith and state, with particular application to sexual and reproductive health.

6.4.3 The UN and Charter of Human Rights

The United Nations (UN) was established in 1945 and its charter was signed by 51 States. It was formed following the League of Nations, which ran from 1920 to

1946, but had a hierarchical nature due to prevailing colonialism at the time. In the newly-formed UN all states were all considered equals. Both were created to work towards the goal of world peace (Stensvold 2016a, 1). Marshall comments that at the creation of the UN 'the focus was squarely on nation states as the appropriate arena for international relations' (Marshall 2017a, 21).

Human rights are the foundation of the UN. The UN charter was its first agreement containing core values of equality, tolerance and peace. The charter was followed by the Universal Declaration of Human Rights (UDHR). Marshall comments that it is often said in jest that 'human rights is the religion of the United Nations' (Marshall 2017a, 20). More serious attempts to link human rights to religion however, are sometimes done in ways that appear to 'proselytize a specific set of beliefs that are insensitive to diverse cultures and norms' (Marshall 2017a, 20); inflexible ideology operates in both religion and secularism and this is where some of the tension lies.

The UDHR includes three references to religion (General Assembly Resolution 1948):

> Article 2: Everyone is entitled to all the rights and freedoms set forth in this Declaration, without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.
>
> Article 16: (1) Men and women of full age, without any limitation due to race, nationality or religion, have the right to marry and to found a family. They are entitled to equal rights as to marriage, during marriage and at its dissolution.
> (2) Marriage shall be entered into only with the free and full consent of the intending spouses.
> (3) The family is the natural and fundamental group unit of society and is entitled to protection by society and the State

> In Article 18: Everyone has the right to freedom of thought, conscience and religion; this right includes freedom to change his religion or belief, and freedom, either alone or in community with others and in public or private, to manifest his religion or belief in teaching, practice, worship and observance

Importantly some of the current tensions at the UN are around individual rights and freedoms of choice (particularly on SRHR), the definition of marriage and freedom of religion, all closely linked to these three Articles. Several authors point out the importance of separation of faith and state to individual rights, the faith community and the state. Andrew Copson, having documented the rise of secularism in three different countries, makes the following comment: 'But if American secularism arose to protect religion from the state and French secularism to protect the individual from religion, Indian secularism has different aims. It seeks to protect people with different beliefs from each other (Copson 2017, 50). Phillip Yancey cautions against 'coziness' between church and state, which he suggests is good for the state, but weakens the prophetic message of faith speaking to the state, quoting Martin Luther King Jr. 'The church… is not the master or servant of the state, but rather the conscience of the state. It must be the guide and the critic of the state, and never its tool' (Yancey 1997, 238, 250).

6.4.4 Types of interaction between faith and state visible at the UN

Katherine Marshall, Anne Stensvold and several other authors document the history and partnership work between religious actors and the UN. This section and accompanying annex 6 will review main points raised in this literature.[15] Religious actors have been actively engaged in different ways with the UN since its inception. In recent years there has been more activity. A wide spectrum of religious actors operates at the UN, mostly working through NGO networks.

[15] Readers are referred to the original authors for further details and analysis (Marshall 2017b) (Marshall 2017b, Vik and Endrensen 2017) (Horsfjord 2016) (Stensvold 2016a) (í Skorini and Petersen 2016) (Karam 2016, Ali, Kowalski, and Silva 2015, Duff et al. 2016).

Conservative religious groups appear to have had more influence (Stensvold 2016a, 1).

6.5 Supporters and strategies

Two case studies of religious discourses at the UN are included in annex 6, which explain how religious actors and MS work together to bring a traditional religio-cultural discourse to UN debates. These are explored in more depth in *Religion, State and the United Nations, Value Politics* (Stensvold 2016c).

6.5.1 UN actors engage FBOs

Over the last decade, there has been increasing interest among UN agencies to engage religious actors (Duff et al. 2016, 95). These partnerships have demonstrated an increasing level of sophistication. Nevertheless, this chapter and annex 6 have highlighted ways in which the activities of some religious groups in partnership with some MS seek to undermine evidence-informed public health, human rights and gender equality. Caution is needed when choosing which religious partners to work with, and which issues to tackle, as Michel Sidibé states:

> It is important in the rush to leverage new faith-based partnerships, international partners draw on the wisdom and experience that already exists within the UN system- and in particular the Inter-agency task force on faith and development (IATF)- rather than pushing ahead with naïve enthusiasm. Rushing in where angels fear to tread can make sensitive and explosive issues worse (Sidibé 2016, 3).

Azza Karam, at UNFPA, cautions against giving FBOs a ‘moral role’:

> By seeking to give the world of faith a role that is primarily “moral” in nature, and even labelling it as such, we are effectively reinforcing the role of religious actors as a “moral compass” to international development efforts. While this may indeed be consonant with the role

> that religious leaders apportion themselves, this does not necessarily affirm the international human rights agenda. In fact, by prioritizing the moral narrative of religion, we risk compromising on the universality of human rights – for not all those who would occupy the moral space agree with the value or relevance of human rights (Karam 2016, 374).

Jean Duff et al provide an overview of the engagement by UN partners with faith and religious groups (Duff et al. 2016, 96). In 2010, the United Nations Interagency Task Force on Religion and Development (IATF) was established at the instigation of the then Secretary General Ban Ki Moon. A series of roundtable discussions of the IATF with faith and multilateral partners has resulted in some important collaborative mechanisms, resource documents, courses, guidelines and criteria for partnership that can inform this engagement.[16]

Azza Karam summarizes the criteria for partnership: that faith-based organizations invited to partner with the UN should engage with a diversity of religious, geographical, ethnic, racial and cultural constituencies and bring balanced gender representation to the table; have existing partnership with the UN; include a mix of religious leaders and faith-based service providers; be legally registered in a country; have no criminal record and not be on any country's terror list (Karam 2016, 367).

To strengthen the engagement of a wide spectrum of faith partners working on the SDGs in line with these criteria and to work towards greater coherence between approaches to partnership with FBOs across the UN, the IATF and partners are working together on several initiatives. These include a platform for collaboration and coordination; publication of a compendium of religious voices

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[16] UNAIDS Consultation and Development of Partnerships Framework for Engagement with FBOs in HIV, 2010 (Sidibé 2016, 3); UNFPA Guidelines for Engaging FBOs as Agents of Change (UNFPA 2013); Formation of the Inter-agency task force on faith and religion (IATF) (Duff et al. 2016, 96); Strategic learning exchange (Duff et al. 2016, 96); World Bank meeting at which Lancet special edition was launched and with Joint Learning Initiative on Faith and Local Communities (JLIF&LC) evidence presented (Duff et al. 2016, 97); Launch of Partnership for Religion and Development (2016) (Duff et al. 2016, 98); Department for International Development (DIFD)-Faith Partnership Principles (Duff et al. 2016, 98).

and perspectives on the SDGs (led by the Partnership for Religion and Development (PaRD)); a working group to develop faith-inspired indicators for the SDGs; an interfaith technical cooperation group on gender equality; and a working group to understand resourcing mechanisms for FBOs (Karam 2016, 372).

Ager and Ager caution against hard secularist approaches that seek to utilize the assets of faith-based service providers, whilst denying the faith motivation which is essential to their existence. They call on international partners to create dialogical engagement and allow action agendas to emerge by embracing diversity, including religious diversity (Ager and Ager 2016, 104). International partners and FBOs must exercise care in this ideological mine-field. Any partnership agenda should be established jointly and involve a broad range of faith partners in setting this agenda, using the SDGs as a framework and the founding principles of human rights as non-negotiables.

6.6 Conclusions

Secularism is the dominant paradigm at the UN. Supporters of hard secularism put this forward as a non-negotiable 'given', which should be respected by all. In this way it is operating as an 'oppressive ideology', 'impermeable to evidence and argument' (Freeden 2006, 6).

There are different types or models of faith/state interaction operational at national level. The national model for interaction generally has a bearing on how the MS will operate in negotiations at the UN.

MS are engaged in different types of collaborative partnerships with religious actors at the UN. Some of these partnerships actively seek to appropriate, and at times, to alter the content of the human rights agenda.

Serious concerns are raised when partnerships between religious actors and member states legitimize the appropriation of human rights by the traditional religio-cultural discourse such that individual rights are subject to interpretation by religious teaching, state actors or a combination of both.

Some MS are willing to include a religious discourse in their interventions and negotiations at the UN. These states tend to resonate with the traditional religio-cultural discourse put forward by the Holy See (also known as 'traditional values'). Supporters of the traditional religio-cultural discourse have actively built this coalition of MS across different religious traditions to support and champion this discourse over many years.

Secularism is supported by a significant group of MS at the UN. MS that support hard secularism generally separate faith and state. This means they will not bring any religious discourse to the negotiating table.

MS that support hard secularism tend to be the countries where the broader religious discourse is the strongest. There is therefore no mechanism for the UN to engage with a broader, pluralistic religious discourses on HIV and SRHR that is supportive of human rights and evidence-based approaches as identified in Strategy 2016 in the policy-making arena.

Separation of faith and state is an important and nuanced concept that can, protect individual rights and freedoms, hold states accountable as duty bearers and bring pluralistic religious voices to critique and guide the state. When hard secularism and traditional religious interpretations of natural law theory act as 'oppressive ideologies' however to exclude other voices, then polarization, tension and conflict can arise.

UN partnerships with religious and faith-based actors on the SDGs should build on the learning, criteria and principles developed by the IATF and engage a plurality of faith partners in defining the partnership agenda together. These partnerships should guard against assigning 'moral roles' to religious actors, which have the potential to re-define the rights and development agenda. These partnerships should also avoid instrumentalizing service delivery assets of faith partners. The challenge is to develop partnerships based on genuine synergies and common ground between religious teachings, public health, human rights,

and gender equality without appropriation or compromise on either side. Chapters 9 and 10 explore ways to do this.

Chapter 7. The broader religious discourse on HIV

7.1 Introduction, key words, research questions

The broader religious discourse on HIV originates from the broad ecumenical Christian faith community working on AIDS and pre-dates the creation of UNAIDS (Kurian 2016, 107). This discourse represents a very wide spectrum of religious opinion including theological approaches from Catholic, Protestant and other faith traditions. It is not one single distinct discourse, but rather a range of overlapping discourses along a spectrum, as indicated in earlier chapters. These approaches to AIDS might be described as moderate or liberal theologically and are welcomed and encouraged by UNAIDS.

This section updates the literature review submitted for this doctorate and addresses material published since 2011. There has been a significant number of review publications produced within this period, as well as advocacy events in advance of the High-Level Meeting (HLM) on AIDS in 2016. Together these provide the best overview of the current discourse.

Key words, phrases and concepts that characterize the discourse include: Compassion; grace; liberation; interpretation; redemption or redemptive; lived-experience; affirm; ethic of life; inclusive; relational; love and mercy; reciprocity; equality; trust; mutuality; autonomy; social justice; challenge patriarchy; transformation; human sexuality; sensitivity; creativity; empathy; change; inclusive; empower; listen; respect.

This chapter attempts to answer these questions:

- What are the main elements of the broader religious discourse in technical literature on HIV, health and SRHR?
- What are the main elements of the broader religious discourse in the Christian literature on HIV between 2011 and 2016?
- What are some of the debates within the broader religious discourse relevant to this thesis?

- Who are the supporters of this discourse in policy negotiations at the UN, and what are their strategies to position this in the PD?

7.2 Framing the discourse from literature

What are the main elements of the broader religious discourse in technical literature on HIV, health and SRHR? This section aims to answer this question through a review of documents containing references to faith and religion produced by UNAIDS and the public health community during this period.

7.2.1 Review of *The Lancet* Series on Faith-based Healthcare

The Lancet, a renowned and, influential journal on public health, published a series on faith-based healthcare in July 2015. This series is considered by the community working at the intersection of faith, healthcare and AIDS as an important landmark. Due to the prevailing secularist theory operating in public health and medical science, there has been longstanding resistance within much of the scientific community to engage with the religious discourse, both in academic literature and in international scientific conferences (Duff and Buckingham 2015, Karam et al. 2015, Olivier 2010). Over the last decade, however, there has been an increase in both literature and partnerships at the nexus of faith, public health, HIV and SRHR.

I review *The Lancet Series* for two reasons: first, its importance to both the public health and faith-based communities working on AIDS, given the significance and influence of this journal. In this context, it marks the beginning of a more pluralistic discourse than the secularist approach traditionally taken by this journal. Second, it demonstrates that there is substantial literature on faith and healthcare, but little scientific research of a quality that can be included in academic publications. This highlights a quality issue, and a difference of worldview between the public health and faith communities around what is important and what constitutes valid evidence.

This publication includes several formal *Comment* papers and three longer academic *Series* papers. The first *Series* paper documents research to estimate scale of health services provided by the faith community (Olivier et al. 2015). The second examines controversies between faith and healthcare (Tomkins et al. 2015). The third discusses strengthening of partnerships between the public health sector and faith-based groups (Duff and Buckingham 2015). As a result of this publication, new research has been funded to fill some of the gaps. Azza Karam and colleagues in their introductory *Comment*, which reviews the special edition, highlight the complexity of issues and debate at the intersection of faith, public health and policy-making and some of the areas of controversy. These include tensions around human rights and gender inequalities, particularly as they affect young women and girls, lesbian, bisexual and transgender (LGBT) people in their attempts to access healthcare. They refer to the lack of consensus around definitions of faith partners working in the field of health, noting that UNAIDS and UNFPA have provided useful working definitions.[17] They highlight the challenges faced by faith-based partners to access funds in an ever-narrowing fiscal environment (Karam et al. 2015, 3). These tensions spill over into the policy-making debates at the UN, which is the subject of this thesis.

> Previous sites of intergovernmental negotiations (including various UN Commissions) have unveiled tensions between elements of human rights discourse and rights-based development praxis, on the one hand, and cultural considerations mixed with national sovereignty to establish governments' own priorities, on the other. These considerations are linked to religious concerns and interpretations, many of which relate to health matters. The fact that some parties to these processes are heavily influenced by certain religious interpretations and concerns is likely to affect progress of these negotiations (Karam et al. 2015, 4).

[17] The Joint United Nations Programme on HIV/AIDS defines faith-based organisations as faith-influenced non-governmental organisations. The United Nations Population Fund defines faith-based organisations as faith-based or faith-inspired non-governmental organisations, with legal standing, which are working to advocate for or deliver development and humanitarian services whether nationally, regionally, or internationally (Karam et al. 2015, 22).

Katherine Marshall and Sally Smith in their *Comment* discuss the roles of faith-based communities and healthcare providers in the Ebola outbreak of 2015. This is an example of the tension between approaches to public health based on a narrower definition of public health, driven by biomedical and technical framing and the broader definition of public health taken in the HIV response (see chapter 3, and annex 3). This difference of approach meant that national governments and international actors did not engage faith-based partners early in the Ebola response (Marshall and Smith 2015, 5).

In *Series* paper 1, *Understanding the roles of faith-based health-care providers in Africa: review of the evidence with a focus on magnitude, reach, cost, and satisfaction*, Jill Olivier and colleagues analyse empirical evidence - focusing on Christian health service providers in sub-Saharan Africa (for which most data are available). They cite the *World Health Report* estimate that faith-based organisations account for about 20 percent of the agencies working on HIV & AIDS (WHO 2004), but refrain from providing an updated figure for the overall proportion of healthcare provided by faith-based health providers, cautioning against such broad estimates. Key messages from this research (Olivier et al. 2015, 8) support the authors' main conclusion that: 'more and improved data are needed to provide support at management and policy levels on every aspect relating to how faith-based health providers routinely function within their health systems' (Olivier et al. 2015, 14).

Series paper 2, *Controversies in faith and healthcare*, considers a wide range of different controversies. The key messages arising from the discussion are important because there are some common threads running through the issues despite their diversity:

> More than 80 percent of the world's population report having a religious faith. Faith-linked controversies in healthcare are often closely linked with culture, social factors and politics; precise attribution is difficult. Child-protection practices, child marriage, female genital mutilation and immunisation vary between and within faith groups. Faith groups differ in their support for healthcare practices including family planning, sexual

> and reproductive health, HIV care and harm reduction. Notwithstanding some differences, there is increasing documentation of different faith groups working together to achieve considerable improvements in healthcare. Policy-makers and faith leaders strongly influence the provision and uptake of healthcare but largely work independently of each other, often lacking knowledge and appreciation. Robust research is urgently needed on the interface between faith and healthcare in order to improve provision and uptake of healthcare, especially for marginalised populations (Tomkins et al. 2015, 14).

Controversies discussed in the paper relating to HIV includes: stigma, sexuality, harm reduction, violence against women and gender. Each controversy is explained, and different perspectives provided on the issue from both a public health and a religious standpoint. Finally, examples are cited of faith groups working to address the controversy in positive ways. The recommendations highlight that the dearth of analysis of these controversies is alarming and that more research is needed to fill these gaps. The authors call for new research to be methodologically rigorous such that it can meaningfully inform policy and practice. They challenge health-care policy-makers to look beyond their silos to the results of successful collaboration between public health and faith-based actors (Tomkins et al. 2015, 24).

In *Series* paper 3, *Strengthening of partnerships between the public sector and faith-based groups*, Jean Duff and Warren Buckingham III, take up the suggestions made in earlier papers around strengthening collaborative partnerships between development and faith partners, and make five recommendations for future action. Their key messages and recommendations are (Duff and Buckingham 2015, 29):

- Focus on global health and multi-sectoral development approaches favours strong partnerships between the public sector and faith-based groups [18]

[18] Multi-sectoral approaches to healthcare include a wide range of partners from different disciplines and are in line with the broad definition of public health discussed in chapter 3.

- Though public sector and faith-linked entities bring distinctive assets that help achieve health goals, ideological challenges present barriers to collaboration and need careful negotiation on both sides
- Faith-based groups' potent influence on health-related behaviours might contribute substantially to health outcomes (e.g., preventable maternal and child mortality) and could be scaled up to national or regional population level
- Models of collaboration between the public sector and faith-based groups exist that could be adapted for sustainable engagement; partnerships with multi-religious coordinating bodies such as inter-religious councils show particular promise

Duff and Buckingham recommend five areas of activity to strengthen cross-sector partnerships:

- Measure and improve communication of the scope, scale, distinctiveness, and results of faith-based groups' work in healthcare
- Appreciate respective objectives, capacities, differences, and limitations
- Increase investments in faith-based groups, and use efficient business models
- Exchange and build core competencies in health and faith in both secular and faith-based groups, and inspire innovation and courageous leadership
- Refrain from using religious teachings to undermine evidence-informed public health practices; refrain from using secularist ideology to undermine effectiveness of faith-based groups' work in health (Duff and Buckingham 2015, 29)

7.2.2 Discussion of The Lancet Series

This important *Lancet Series* demonstrates interest and willingness from the public health community to engage with faith partners working on health. This relatively new interest has emerged despite much resistance. This is an

important message to the secularist public health community. *The Lancet,* considered a bastion of scientific rationalism, recognizes that faith-based healthcare networks are important, both in the scale and scope of their healthcare provision, and in their understanding of local cultures and practices that affect health, and that more research is required to engage faith actors effectively. It also recognizes that there is a need to strengthen the evidence base on the health services provided by faith-based partners and to strengthen their technical capacity in some areas. Here is evidence that some leaders in the field of public health are questioning traditional boundaries and looking to explore new partnerships in healthcare.

The final *Series* paper proposes some general ways forward to strengthen partnerships and this has resulted in increased investment in this work. The President's Emergency Plan for AIDS Relief (PEPFAR) together with UNAIDS launched an initiative in 2015 to scale up work in these areas, and address the gaps highlighted by *The Lancet*. Focus areas of the initiative include: i) data collection on the scale, scope and reach of the faith-based health service providers and capacity-building among these partners; and ii) work with WCC to address controversies around HIV, SRHR, stigma and discrimination.

These key messages and conclusions confirm several issues identified in this thesis: firstly, that the 'lingering controversies', frequently linked to the influence of the traditional religio-cultural discourse, some of which are discussed in *Series* paper 2, contribute to reticence to engage with faith-based health service providers (Olivier et al. 2015, 8). These controversies support hard secularist approaches, which traditionally resist engagement with the faith-based sector (see chapter 6) and contribute to the ongoing lack of robust data in this area. *The Lancet* acknowledges the ideological tensions between faith and public health perspectives, specifically around HIV and SRHR. This is where the *Series* is of particular relevance to this thesis. The *Series* paper on controversies, however, does not analyse the issues in enough detail to make specific recommendations on the way forward in each area. The controversies between faith and public health approaches to HIV and SRHR are unpacked in much greater depth in the publication subsequently released in 2016 by UNFPA and

NORAD entitled, *Religion, Women's Health and Rights: Points of Contention and Paths of Opportunities*, (UNFPA 2016).

7.2.3 Review of Religion, Women's Health and Rights: Points of Contention and Paths of Opportunities

This publication documents the results of an ongoing journey by UNFPA, NORAD, UNAIDS and a broad spectrum of faith partners to explore evidence and document the benefits of sexual and reproductive health and reproductive rights for women and girls (UNFPA 2016). This includes discussion of the roles of culture and religion in shaping, guiding, facilitating and limiting approaches that work for women and girls.

The UNFPA study highlights that: beliefs and faith institutions are affected by changes and modernization in society that have changed the sexual and reproductive health environment for women and couples; these changes 'call traditional approaches into question'. Nevertheless some common beliefs in 'core human rights and in the irreducible value of human life' (UNFPA 2016, 9). Through a series of partnerships between UNFPA and a range of faith-based partners there is evidence of common ground between theology and human rights.

Many of these initiatives, rooted in different religions, argue for the need to reinterpret religious texts and injunctions with a view to girls' and women's welfare. While the calls for interpretation are deeply contentious in a terrain long dominated by patriarchy, they are particularly debated when it comes to issues of sexual and reproductive health (UNFPA 2016, 11).

The publication includes definitions of the terms sexual and reproductive health (SRH) and reproductive rights (RR) and explains religious traditions and their teachings on women's roles (UNFPA 2016, 19). It provides analysis of the contentious issues relating to SRH and RR for women and girls from the perspective of the major religious traditions, giving examples from the religious traditions of support for the elements of SRH and RR. This publication provides a

solid, detailed articulation of the broader religious discourse, with respect to women, girls and SRHR.

7.2.4 What are the main elements of the broad religious discourse in the Christian literature on HIV between 2011 and 2016?

This section is structured under seven headings:

- Policy, advocacy and accountability (speaking to the church)
- The scale, scope and reach of the faith-based health service providers
- Practical action, inclusion and the GIPA principle
- Theological reflection and dialogue
- Human sexuality, gender and violence
- Advocacy and political activism (speaking to the world)
- Faith: part of the problem and part of the solution

7.2.4.1 Policy, advocacy and accountability (speaking to the church)

In 2016 the WCC released a history of the Ecumenical Churches' response to AIDS over thirty years, entitled *Passion and Compassion* (Kurian 2016). This is an important review of the history, content and tone of a broad faith-based HIV response from Christian actors who have led the way in developing this discourse. This discourse is deeply rooted in theological reflection and seeks to find areas of resonance with approaches based on human rights, gender equality and scientific evidence. Kurian notes a change in the tone of the response over time, from charity to humility, demonstrating an increased willingness to learn from those on the margins of society (Kurian 2016, viii). This thesis argues that this approach differs markedly from that of the supporters of a traditional religo-cultural discourse, which focuses more on the preservation of doctrine and a conservative position on women, marriage, sexuality and families.

The WCC ecumenical movement includes 350 partners (each of which is a large grouping of churches); the Anglican, Eastern and Oriental Orthodox, Old Catholic, Protestant, independent and united churches (World Council of Churches 2018). The primary role of the WCC is to lead and convene these

churches, maintaining accountability to its members (Kurian 2016, 6). WCC first held an AIDS conference in 1984. Following a period of intense discussion and some internal opposition due to the linkages between AIDS, concepts of sin and homosexuality, the WCC Executive Committee issued a statement on AIDS in 1986, which was ground-breaking in its language, much of which remains contested ground (Kurian 2016, 7).

The statement challenges the church to repent of rigid moralism and provide pastoral care for all, without barriers, exclusion or rejection. It affirms: the importance of providing high-quality information, based on the WHO and other technical documents; HIV prevention measures reflective of clearly understood transmission mechanisms; behaviour change and responsibility; 'the right to medical and pastoral care regardless of socio-economic status, race, sex, sexual orientation or sexual relationships'; privacy; confidentiality; and global collaboration. The Executive Committee called for ecumenical churches to avoid judgement and condemnation, to support the medical and research community, and to respond in love and mercy, free from simplistic moralizing in the face of a virus (Kurian 2016, 7-8).

This statement, whilst recognizing the areas of tension within the teachings and practice of ecumenical churches, also recognizes the need to avoid rigidity, moralizing, condemnation and rejection. It does not protect doctrine at the expense of grace and encourages collaboration with the medical and research professions in the face of a devastating epidemic. This statement, I suggest, includes the main elements of the broader religious discourse on AIDS, and sets the tone for the next thirty years of the ecumenical HIV response. When compared with the main elements of the traditional religio-cultural discourse outlined in chapter 5 there are clear differences. This discourse has engaged in theological reflection on the Biblical texts with a focus on compassionate action in the face of a crisis, in partnership with other actors, rather than on the protection of rigid doctrine.

This broad religious discourse has developed in parallel to the traditional religio-cultural discourse on HIV and AIDS and can be traced back to the early WCC

statements. In contrast to the confrontational approach taken by traditional religious actors in preparation for the Beijing Conference on Women in 1995 (discussed in chapter 5), the WCC hosted a consultation of women from sixteen countries, spanning five continents, in India and produced the following Platform of Action:

> We call upon our churches to engage in self-critical examination of the church's participation in and perpetration of cultural biases and patterns that contribute to women's subordination and oppression.
>
> We urge our churches to create an environment where the life experiences of women can be heard without fear of judgement, in an atmosphere of mutual trust and respect, so that the issues that emerge may be addressed.
>
> We strongly recommend that the churches re-evaluate the ways in which we have interpreted the Bible, along with church traditions and images of God. Many Christians have accepted these as truth without considering how far they are (or are not) rooted in people's daily realities, and consistent with the liberating message of Jesus.
>
> We challenge the churches to acknowledge openly the sexual dimension of human experience and allow for this dimension to become part of ongoing church dialogue.
>
> We commend this platform of action to our churches worldwide in the loving hope that they will remember always, in their consideration, reflection and prayers, that these issues have to do not only with abstract ideas but with real people, the quality of their lives, and their well-being and health (Paterson 1996, 11).

A process followed, during which a group, mandated by the WCC Central Committee, grappled with some of these issues. Despite the group having diverse and potentially irreconcilable differences at the outset, the outcome

was a powerful statement and a study document recommending clear policy guidelines for churches to follow in response to the AIDS epidemic (Kurian 2016, 11). This constitutes the most comprehensive and authoritative early statement of the broader religious discourse. Dated 1997, this text has informed the work of many of the WCC member churches on HIV since then.

Core elements of the 1997 WCC statement are in line with the broad definition of public health, human rights, gender equality and community engagement outlined in chapter 3. Notably, it calls for a climate of love, acceptance and support based on theological and ethical reflection and participation in the discussions within wider society on HIV. Churches are urged to provide guidance on difficult issues, advocate for better care for PLHIV, give special attention to the needs of infants and children and safeguard, develop and promote the rights of PLHIV. It calls for churches to promote the dissemination of accurate information, advocate for increased spending on the HIV response and research, recognize the linkages between AIDS and poverty and strive for justice and development. Churches are asked to: focus on situations that increase vulnerability to HIV, including migration, refugee movements and sex work; enable women to achieve their full dignity and express their gifts; involve young people and men; regard human sexuality as a gift; explore the issues of responsibility, relationships, family and faith; approach drug use with responses based on care; and to address addiction, rehabilitation and prevention (Kurian 2016, 11-12).

These statements were prophetic and demonstrate a shift of emphasis from condemnation of personal sin to protecting the rights and dignity of the most vulnerable, including addressing structural sin; all of which are central to this broader religious discourse.

The next major development in the ecumenical HIV response was a series of consultations, culminating in a global consultation on AIDS in Africa in 2001. A paradigm shift took place at this conference: WCC member churches for the first time condemned discrimination and stigma towards PLHIV as a sin, and against the will of God. The plan of action resulting from the consultation led to the

process which created the Ecumenical HIV and AIDS Initiative in Africa (EHAIA) in 2002. It had two objectives: to build the competence of churches in Africa to address the epidemic; and to develop materials for theological training curricula, to influence the mainstream education of church leaders in Africa (Kurian 2016, 14-15).

This initiative differs from the traditional religio-cultural discourse because it involves informing its own members about how to respond to HIV in ways that are consistent with human rights, gender equality and in collaboration with other partners. This broad religious discourse has not been peripheral to the mainstream church, half-hearted, superficial or short-lived. It is grounded in theological reflection and academic scholarship over three decades and involves churches from 350 major church denominations spanning all continents.

However, this discourse is almost invisible in global policy-making on AIDS. Reference to religious approaches to HIV that are supportive of human rights, gender equality and scientific evidence are missing from the text of all the PDs on HIV & AIDS. Later chapters will explore some of the reasons for this, but it is important at this point to acknowledge the strength of this discourse and the breadth of its base.

7.2.4.2 The scale, scope and reach of faith-based health service providers

One thread of this discourse has been a substantial body of literature to document the work of Christian healthcare providers, and to build their competency in providing healthcare for PLHIV. Authors including James Cochrane, Jill Olivier, Quentin Wodon, Gillian Paterson, Beverley Haddad and John Blevins have written extensively on the work of the African and other Christian health associations on AIDS. The African Religious Health Assets Programme (ARHAP) was created to research and understand these assets (Cochrane 2006, Olivier et al. 2006, Haddad 2011, PEPFAR 2015, Oliver and Wodon 2012, Paterson 2011).[19]

[19] The main findings of this literature base have been summarized in *The Lancet Series* paper 1 discussed above (Olivier et al. 2015)

This literature is honest about the strengths and weaknesses of the faith-based health service provision on HIV, and the quality of the evidence base which supports it. Greg Manning highlights inconsistencies in some reporting of religious work on HIV. He urges practitioners not to confuse HIV prevention with belief systems that attempt to 'heal society from promiscuity, men who have sex with men from homosexuality, or heal people using illicit drugs from drug addiction' (Manning 2011, 53). He calls for greater mutual accountability, firstly from the faith sector in reporting accurately and critically evaluating their work, and highlights the role of the faith sector in holding state providers of healthcare accountable (Manning 2011).

In response to the gaps identified by this literature the Academic Consortium of the PEPFAR/UNAIDS FBO Initiative, is working to collect and analyse data and strengthen the capacity of faith-based health service providers on HIV and AIDS service provision. The absence of clear and accurate data on the scale scope and quality of faith-based health service provision on AIDS is important because it contributes to the invisibility of the broad religious discourse on HIV in the secular public health and HIV field.

7.2.4.3 Practical action, inclusion and the GIPA principle

In addition to the formal work of the faith-based healthcare providers there has been a groundswell of practical action from local churches, especially in sub-Saharan Africa in response to AIDS. The details of this multifaceted response are beyond the scope of this review, but one area is of particular importance, and that is the engagement of people living with HIV in care and support, and advocacy both within and beyond the Christian Church. Over 20 years (1981-2000) the number of PLHIV rocketed to 34.3 million (UNAIDS 2000, 6). PLHIV responded to fill a gap by providing care and support, as many government responses were sluggish. Advocacy and activism by PLHIV launched a new paradigm in public health, where the involvement of people living with a disease became central to the response.

The movement gathered pace as more PLHIV were willing to disclose their HIV positive status. Within the faith community one of the first religious leaders to disclose his HIV status (in 1992) was the Reverend Canon Gideon Byamugisha from Uganda. In 2003 he and others, including the Reverend Johannes Petrus Heath, Reverend Christo Greyling and Reverend Phumzile Mabizela, co-founded the African Network of Religious Leaders Living with or personally affected by HIV (ANERELA+) (Kurian 2016, 46). This movement has been central to the broader religious discourse on HIV, as it has provided an authentic voice of the lived realities of religious leaders who openly acknowledge their HIV status, hold firm to their faith, and challenge the church to re-examine moralistic and rigid teachings on sexual and reproductive health, gender equality and rights. These four leaders have each taken forward leadership and practical action to support people living with HIV to live positively with the virus and have pioneered work within the church to engage people living with HIV as central to the faith response.

The reason for including these examples of the ecumenical churches acting as a healing community is to demonstrate not only the principal of GIPA, but also the theological concept of grace. One clear difference between the broad religious discourse and the traditional religio-cultural discourse is the contrast between an approach of grace, and one of law. Chapter 6 highlighted differences between visionary political leadership and the fear-based, protectionist national sovereignty discourse. The broader religious discourse is characterized by similar elements to the political leadership discourse. It is visionary, inclusive, partners with a broad spectrum of actors, is willing to challenge the status quo and interrogate interpretations of religious texts and teachings in light of new realities. The focus is on grace, mercy, compassion and inclusion rather than on the legalistic and protectionist preservation of doctrine and morality.

Canon Gideon Byamugisha as Christian Aid’s AIDS Ambassador was instrumental in designing the training materials known by the acronym SAVE to replace the ABC approach to HIV prevention.[20] Based on four interventions: S, stands for

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[20] The ABC approach to HIV prevention included: Abstinence, being safer (by being faithful or reducing the number of partners), and correct and consistent condom use (UNAIDS 2004).

safer practices; A, for Appropriate treatment and nutrition; V, for Voluntary counselling and testing; and E, for Empowerment. This methodology is now taught by Christian Aid and INERELA+ based on the SAVE toolkit across the world (INERELA+ 2017). This approach avoids the dichotomy of abstinence versus condoms, using an acronym with which the faith community resonates. The concept of SAVE, saving lives, is closer to the Christian concept of grace than the abstinence versus condoms debate, which perpetuates a conflictual dichotomy focused on legalistic approaches to sexuality.

In June 2006, Canon Gideon addressed the UNGA gathered to negotiate and adopt the 2006 PD on HIV & AIDS. As the representative of PLHIV he made this statement:

> Assembly members came to this meeting with positions to defend or positions to negotiate, but they will leave with a choice to make: either continue with tokenism or transform the AIDS landscape with total commitment. Tokenism means moving on without clear targets, pledging a little money for cosmetic purposes, signing documents and issuing press releases. On the other hand, total commitment means fully implementing the policies, programmes and partnerships that we know work. Total commitment is also demonstrated by fully mobilizing the participation of people living with HIV & AIDS, embracing firm targets and meeting them by 2010, promoting and protecting the rights of women and children and empowering them, implementing comprehensive, evidence-based, informed and rights-based prevention strategies, ending stigma and discrimination, identifying and responding to the needs of all vulnerable groups, and ensuring that no task-focused, results-oriented, evidence-led and well-costed national strategy goes unfunded or underfunded. This is an important choice to make, and a heavy responsibility, too: tokenism or total commitment against AIDS (United Nations 2006, 88).

In contrast, the intervention delivered on behalf of the Holy See by Cardinal Barragán stressed the scale and scope of the work of the Catholic Church in responding to the epidemic, The intervention was focused on what the church

does ‘to and for’ PLHIV, and contains elements of the traditional religio-cultural discourse:

> Our main training programmes are addressed to healthcare professionals, priests, religious, the sick themselves, families and young people. In prevention, we stress information and education towards behaviour that will avoid the pandemic. We understand that the contributions of the family are vital and effective in the field of education and training. We provide education and training also through publications, conferences and the sharing of experiences and skills. As for healthcare and assistance to the sick, we stress the training of physicians, paramedical personnel, chaplains and volunteers. We fight stigma, facilitate testing, counselling and reconciliation. We provide anti-retrovirals and drugs to stop vertical mother-to-child transmission and blood contagion. In the area of caring for and supporting the sick, we stress avoiding contagion and taking care of orphans, widows and prisoners (United Nations 2006, 82).

The tone of Cardinal Barragán’s intervention is significantly different from that of Canon Gideon’s and demonstrates the differences between a traditional religio-cultural discourse and the broad religious discourse. Canon Gideon calls on MS to act with visionary political leadership. Here is a religious leader whose call to MS is supportive of equality, rights and evidence. Some of Cardinal Barragán’s language is stigmatizing and patronizing of PLHIV, referring to ‘contagion’ and suggesting that training programmes should be addressed ‘to’ PLHIV, rather than developed in partnership ‘with’ them. It focuses on the role of the Catholic Church in fighting the epidemic, not its role in responding to the needs of those living with HIV. Rather than calling on political leaders to take bold decisions, it reiterates elements of the traditional religio-cultural discourse that the Holy See wishes MS to adopt in national responses, such as education on behaviour change to avoid sexual and other activities that will lead to contagion. It emphasises the role of the family as central to education.

The work of the other co-founders of ANERELA+ has also broadened and deepened the churches’ response to HIV in ways that develop the broad religious

discourse. Reverend Greyling has developed the World Vision training course 'Channels of Hope' and rolled this out across more than forty countries. This training is a methodology for mobilizing community leaders to respond to the issues of HIV and AIDS. It takes religious leaders through the technical information on HIV and engages them in theological and personal reflection that is transformative. Religious leaders following the training often make statements indicating their shift from a traditional religo-cultural world-view to broader religious world-views (World Vision 2013, 4).

In 2006, ANERELA+ became the International Network of Religious Leaders Living with or personally affected by HIV (INERELA+). Reverend Heath, former Executive Director of INERELA+, now works as Policy Advisor on HIV and Theology for the Church of Sweden. In this role he leads work on HIV and theology concerning sexuality and sexual orientation, including a collaborative project between the Church of Sweden and the Global Interfaith Network for people of all Sexes, Sexual Orientation, Gender Identity and Expression to critically examine how the sacred texts and religious practices of Jews, Christians and Muslims respond to sexual orientation and gender identity (Tulleken and Mokgethi-Heath). This approach is characteristic of the broad religious discourse, which revisits traditional interpretations of religious texts in light of current realities and lived experiences of those on the margins of society, especially where that marginalization is fuelled and further entrenched by the application of religious doctrine.

The global movement of PLHIV led to the articulation of the Denver principles of involvement and has shifted the way public health is practiced across the HIV response (UNAIDS 2015b, 80). It has been a driving force within the broad faith movement on HIV, promoting theological and practical approaches to HIV that are in line with scientific evidence, human rights and gender equality.

7.3 Conceptual Frameworks

7.3.1 Theological reflection and dialogue

In three decades, the theological and ethical literature on HIV has burgeoned. Many publications have been collected together in the annotated bibliography of the Collaborative for HIV and AIDS, Religion and Theology (CHART) database (Haddad 2011). These and the publications of the WCC provide the theological framework for the broader religious discourse, which is supportive of the conceptual frameworks outlined by the Council of Europe and Parker and Aggleton, described in chapter 4. This section describes the major themes in this theological literature and how they havechanged over time, particularly as they pertain to the origins and development of the broad religious discourse.

The substantive publication edited by Beverley Haddad reviews the literature held in the CHART database and provides a comprehensive update on the different themes in the literature (Haddad 2011). Much of this theological writing has been mainstreamed into theological education across Africa, through the Ecumenical HIV Initiatives and Advocacy (EHAIA) project. This is important in shaping the responses of a broad spectrum of ecumenical churches on the ground because there is often a time lag between the academic and theological literature and practice in local churches. Thematic areas in this literature are expanded in the sections below.

7.3.1.1 AIDS as a punishment from God

This was a feature of early theological reflection in the HIV response. Gerald West's review of CHART literature on the use of sacred texts in the HIV response discusses the theology of retribution in both Christian and Islamic sacred texts in Africa as contributory factors to stigma and discrimination. West describes approaches to the reading of religious texts, which affirm concepts of human dignity and the image of God, especially when the texts are read and interpreted by people living with HIV. The methodology of contextual Bible study, developed by the WCC EHAIA project, which involves grounding readings of sacred texts in the local and lived experiences of PLHIV and highlighting Jesus' identification with those who are stigmatized and marginalized, has helped to overcome judgemental and stigmatizing interpretations by religious leaders and authorities (West 2011, 145). Other recent literature concludes that

there is no justification to make the connection between AIDS and God's punishment (Gill 2007, Chitando and Nontando 2009). Jill Olivier notes that despite the depth of theological reflection on this and other important theological issues, the practical responses of many churches are not always grounded in these theological frameworks (Olivier et al. 2006: 60).

7.3.1.2 Prophecy, suffering and lament, healing and compassion

Prophecy, stigma and discrimination, healing, compassion, suffering and lament are explored by a range of authors (Olivier et al. 2006, Chitando and Nontando 2009, Dube Shomanah 2009, Messer 2004). The Biblical books of Job and the Psalms have been sources of theological reflection on lament and suffering. West reviews the work of Ken Stone and Patrick Adeso, who argue that suffering is not linked to sin, and that lament within the psalms can be used to address some of the more disturbing religious responses to AIDS (West 2011, 144-149). West describes how an understanding of compassion emerges from the HIV literature. Monica Melanchthon, in her response to West's chapter, concludes that liberative readings of sacred texts on HIV are urgently called for (Melanchthon 2011, 169). In the context of compassion and the healing work of the ecumenical churches, authors have drawn a theological link between the body of Christ and AIDS. The theme 'the body of Christ has AIDS' has been central to the work of Dube, Ackerman, Klinken, Byamguisha and others (Klinken 2010).

7.3.1.3 Moral theology, values and ethics

Moral theologians have explored ethical and theological teachings on HIV prevention and treatment, and sexuality. Domoka Manda documents the shift from a theology that views AIDS as a punishment from God to one that promotes and affirms life. Ethical values of 'relationality, inclusivity, love, care and compassion' are central to this approach (Manda and Haddad 2011, 201). Early literature takes a moralistic, rule-based approach to HIV and AIDS, with a strong focus on sexual morality and a discourse of blame towards those living with HIV. This approach still characterises the traditional religio-cultural discourse on AIDS. Broader religious and ethical reflection on AIDS, however, has included a

shift in tone towards an 'ethic of life' (Manda and Haddad 2011, 204). Manda quotes Armin Zimmerman, who argues for a shift in traditional sexual ethics:

> Thus there should be the development of a new Christian sexual ethic that focuses not only on promoting safe sex, but also on promoting values such as reciprocity, mutuality, respect, love, fidelity, trust and equality between the sexes (Zimmermann 2004, 267).

A second change in theological literature identified by Manda is the shift from compassion towards theologies of justice. Earlier theologies of compassion, linked to suffering and pity have matured into approaches that take account of the issues of agency and control (Manda and Haddad 2011, 208). These shifts provide theological and practical foundations for the broader religious discourse, and they align with the conceptual framework of Parker and Aggleton, which moves from approaches to stigma based on building the individual's capacity to cope, to approaches aimed at addressing the structural drivers of stigma (see chapters 3 and 4).

7.3.1.4 Grace as a theological theme.

As mentioned briefly in Chapter 5. The grace/nature distinction and debate is of great historical significance in Christian moral theology, and dates back to the Church Fathers (Ormerod 2014, 515). It begins with the debate between Augustine (354-430) and Pelagius on natural law and grace, around the central question of whether it is possible to please God without grace. Augustine argues that sin has clouded human freedom and the ability to follow natural law,[21] and without grace people are not able to avoid evil or gain salvation through human effort alone, thus contradicting Pelagius (Ormerod 2014, 518) (Brotherton 2014, 545). Thomas Aquinas (1225-1274) picks up the discussion a century later. He argues that because of sin people are unable to respond to the natural desire for God, to know God. He adds the question of whether it is possible to will or do good without grace and concludes that people are able to do some naturally

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[21] **Isaiah 59:2** But your sinful acts have alienated you from your God; your sins have caused him to reject you and not listen to your prayers.

good things, ‘such as building houses’ but are unable to know God, because to know God grace is required and grace is ‘supernatural’. Aquinas therefore, also rejects Pelagian anthropology and takes the debate a step further than Augustine, introducing the concept of supernatural grace (Ormerod 2014, 521, 522).[22]

Neil Ormerod reviews Aquinas’ discussion of the impact of Adam’s fall on humankind and his construct of ‘pure nature’.

> Human nature is good in itself prior to original sin, and can attain the good proportionate to it, but not the supernatural good of salvation, which requires God’s grace. After the Fall, human nature is weakened and can attain the good proportionate to it only in a spasmodic fashion. In this fallen state grace is necessary for two reasons: first, to heal our weakened orientation to the good; second, to elevate our nature to a higher end, to be able to attain God…(Ormerod 2014, 522)

And on the question of whether one can gain eternal life without grace:[23]

> Now eternal life is an end which exceeds what is commensurate with human nature. . . . It follows that a man cannot, by his natural powers produce meritorious works commensurate with eternal life. A higher power is needed for this, namely, the power of grace. Hence a man

[22] **Romans 4:1-5** What then shall we say that Abraham, our ancestor according to the flesh, has discovered regarding this matter? 2 For if Abraham was declared righteous by the works of the law, he has something to boast about (but not before God). 3 For what does the scripture say? “Abraham believed God, and it was credited to him as righteousness.” 4 Now to the one who works, his pay is not credited due to grace but due to obligation. 5 But to the one who does not work, but believes in the one who declares the ungodly righteous, his faith is credited as righteousness.

[23] **Ephesians 2:8-9** For by grace you are saved through faith, and this is not of yourselves, it is the gift of God; 9 it is not of works, so that no one can boast.
Titus 3:5-7 he saved us, not by works of righteousness that we have done but on the basis of his mercy, through the washing of the new birth and the renewing of the Holy Spirit, 6 whom he poured out on us in full measure through Jesus Christ our Saviour. 7 And so, since we have been justified by his grace, we become heirs with the confident expectation of eternal life.

> cannot merit eternal life without grace, although he can perform works which lead to such good as is natural to him (Ormerod 2014, 522).

After Adam's fall God set up a plan for the salvation of mankind through Jesus Christ, which is the central message of the Biblical New Testament [24] and explained by the International Theological Commission (see Chapter 5 section 5.3). The main elements of this Biblical teaching are accepted by both Roman Catholics and Protestants (International Theological Commission 2009, 101).

Within Roman Catholicism there are longstanding and significant theological discourses and debates building on the work of Augustine and Aquinas, on the distinction between universal natural law, and grace; including the role of the church as the primary manifestation of God's grace, Jesus Christ's death bringing salvation to mankind and the presence of the Holy Spirit in the world today. The prominent theologian, Bernard Lonergan engaged in the debate in the early 20th Century, adding the concept of a 'scale of values' to Aquinas' discussion of nature and grace, and introducing the idea of grace, through forgiveness as a 'healing vector' within society 'transforming individuals' to become 'agents of change' within society (Ormerod 2014, 531). Theologians including Henri de Lubac, Karl Rahner, Edward Schillebeeckx, Bernhard Lonergan and Hans Urs von Balthasar have engaged with concepts of the supernatural and gratuitous nature of grace in relation to natural law (Ormerod 2014, 525).

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[24] **Romans 5:8** But God demonstrates his own love for us, in that while we were still sinners, Christ died for us.
Romans 4:25 He was given over because of our transgressions and was raised for the sake of our justification.
2 Corinthians 5:21 God made the one who knew no sin to be sin for us, so that in him we would become the righteousness of God.
1 Peter 3:18 Because Christ also suffered once for sins, the just for the unjust, to bring you to God, by being put to death in the flesh but by being made alive in the spirit.
John 1:12 But to all who have received him--those who believe in his name--he has given the right to become God's children
John 3:16-18 For this is the way God loved the world: he gave his one and only Son that everyone who believes in him should not perish but have eternal life. 17 For God did not send his Son into the world to condemn the world, but that the world should be saved through him. 18 The one who believes in Him is not condemned. The one who does not believe has been condemned already, because he has not believed in the name of the one and only Son of God.

Several authors including, Agbonkianmeghe Orobator and Neil Ormerod take up the issues of women and gender as an example to illustrate the complexity of the Church as the sacrament of God's grace in the world (Orobator 2012, Ormerod 2014) .

7.3.1.4.1 The Holy Spirit and the Church

God's Holy Spirit, is the third member of the Holy Trinity, who was poured out into Christian believers at Pentecost.[25] He then becomes the visible manifestation of God's presence on earth. The body of believers, who have through faith in Jesus Christ been filled with the Holy Spirit, make up the church, which is the channel for expression of Jesus Christ's redemption and grace in the world (Gaillardetz 1999).

Catholic theology considers the Church as a 'sacrament', namely, 'the visible expression of Christ's grace and redemption' in the world (Gaillardetz 1999, 3). Brian Gleeson and Richard Gallardetz discuss challenges inherent in this 'sacrament', presented by the Catholic concept of a 'perfect Church'. If the Church is perfect and represents God's grace in society today, then the realities of the Church as a gathering of sinful people; of patriarchy and individualistic theism are problematic (Gleeson 2005, 4) (Gaillardetz 1999).

The concept of the 'perfect' Church has been taken as licence to strengthen its structural, legalistic, dogmatic patriarchal and institutional nature, which alienates people seeking grace, and excludes women (Orobator 2012, 18) (Ormerod 2014, 530, Cahill 2014). Agbonkianmeghe Orobator goes further to illustrate the impact of this debate between natural law and grace, and the role

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[25] **Acts 2: 1-4** When the day of Pentecost came, they were all together in one place.2 Suddenly a sound like the blowing of a violent wind came from heaven and filled the whole house where they were sitting. 3 They saw what seemed to be tongues of fire that separated and came to rest on each of them. 4 All of them were filled with the Holy Spirit and began to speak in other tongues[a] as the Spirit enabled them.

Acts 2 14-17 Then Peter stood up with the Eleven, raised his voice and addressed the crowd: "Fellow Jews and all of you who live in Jerusalem, let me explain this to you; listen carefully to what I say. 15 These people are not drunk, as you suppose. It's only nine in the morning! 16 No, this is what was spoken by the prophet Joel: 17 'In the last days, God says, I will pour out my Spirit on all people……… And everyone who calls on the name of the Lord will be saved'.

of the church as a sacrament of God's grace to society, on people living with HIV, many of whom are women.

One purpose of this section has been to demonstrate the complexity, nuance and internal debate within Catholic theology around grace as a theological theme. An important element in the Catholic theological discourse is the impact of the Reformation, the Enlightenment and secularist thinking, which sought to challenge the power of the Monarchy and the Church through the 16th to 18th Centuries in Europe. There are important areas of overlap with Protestant theology of natural law, grace, the church as a sacrament and the work of the Holy Spirit. Some of the richness of both Catholic and Protestant theology in these areas have been refined through the struggles of the Reformation.

Raymond Smith documents, for example, the emphasis on the work of the Holy Spirit in the writings of the English Reformers of the 16th century (Smith 1964, 2). The re-discovery of the individual, with the Reformation's emphasis on salvation by faith, the outpouring of God's Holy Spirit into individuals and the church as a body of individual believers who were filled with the Holy Spirit were all part of the Movements' exploration of individual religious freedoms and rights, and the boundaries between individual, church and state (Smith 1964, 54 , 55). In this context it is important to note that the physical human body of the individual believer is the temple of the Holy Spirit, and as such the teaching on sexual morality is strong.

The Reformers challenged the concept of Church held by Rome as too narrow and argued that 'Church was not limited to their confines. At one stroke the Church was liberated from the confines of a legalistic institution and was able to be thought of in relationship to the cardinal doctrine of justification by faith'. In addition, the Reformers highlighted the possibility of error both of the individual and the church and the need for caution in matters of church government (Smith 1964, 135, 162).

The definition of a sacrament was also challenged by the Reformers, the Papists listing seven sacraments and the Reformers arguing that there were only two, namely, Baptism and the Lord's Supper (or Holy Communion), because these were direct instructions of Jesus (Smith 1964, 170).

Through the upheavals of the Reformation, the Enlightenment and revolutions from the 16th to 18th centuries, some important shifts took place, which influenced the direction of Christian faith, secular governance and society, and have longstanding impact on the intersection of religion, state, law and human rights to this day. The authority of the Roman Catholic Church to define Christianity was challenged and a more pluralistic array of Christian expression of faith and church emerged. The right of the individual to choose their faith, was introduced as a new expression of religious freedom. Secular states defined their relationship to churches and to individual's rights in new ways. Religious freedom was no longer defined only as the freedom of the institution of Church from state interference. The seeds of pluralism in Christianity, secularism, modern individualism, liberal theology, human rights and a privatization of faith were sown (Smith 1964) (Gaillardetz 1997) (Orobator 2012) (Copson 2017). These tensions are all evident in negotiations at the UN to this day on issues around sexual and reproductive health and rights, HIV and gender.

Richard Gaillardetz and Agbonkianmeghe Orobator discuss this influence of modern individualism on Catholic theology of grace in the marketplace. When the Roman Catholic Church is faced with aggressive individualistic secularism then its pluralistic, Trinitarian and more nuanced discourse is in danger, and what emerges is a more legalistic articulation of a dogmatic and patriarchal doctrine the casualties of which are often women and the marginalized, extending at times to exclusion, judgement and rejection of people living with HIV (Gaillardetz 1997, 6) (Orobator 2012, 19). Gaillardetz laments the theological retreat into a portrait of God as King, Lord, Master and Father-Patriarch to the exclusion of Christ and the experience of the Holy Spirit. This results in hunger for a deeper and greater intimacy with God, which in turn leads to a search for 'spiritual injections'; these, he argues, reduce grace to a commodity and the Church to 'sacramental grace dispensers'(Gaillardetz 1997, 6). This sits in contrast to the richness of the Trinity as a 'pulsating divine movement' of love, and God's desire to draw us towards Himself in relationship. 'This model suggests an alternative way of conceiving the life of grace, a vision of God's way of being present with us which is revealed in the fundamental doctrine of the Christian faith, the trinity'(Gaillardetz 1997, 8).

> We live this life of communion as at the same time, the life of the Spirit. It is the Holy Spirit who draws us into communion with God through Christ as we enter into authentic communion with God's creatures. This same Spirit draws us together as a eucharistic assembly or communion—a church. In the liturgy that same Spirit, working through the ritual action of the community both reveals the distinctive paschal pattern of the life of communion and draws us into that pattern. As Christ is in our midst at the altar offering himself for the life of the world, we unite ourselves with Christ through our participation in the liturgy and so offer our lives to God in loving service of one another. At the table of the Lord we are drawn by the Spirit into eucharistic koinonia, eucharistic communion. At the conclusion of the liturgy we are sent forth to live the life of communion. And so we live--from communion to communion, ever born by the Holy Spirit who is the love of God abiding in us (Gaillardetz 1997 15).

I include these two quotations to demonstrate that there is some similarity within Catholic theological thinking and discourse and that of the Reformers. Gaillardetz and Orobator both refer to Vatican II as a movement intended to promote greater inclusion by Rome, intended to address the challenges of Catholic faith and doctrine in this modern secular and individualistic world; an attempt to encourage greater participation. Orobator argues however, that it has been used by some to continue to exclude women, which he explains has impact in Africa in the context of the HIV epidemic where women are the backbone of the Church's caring community. This critique of the church as unwelcoming and lacking grace in its response to people living with HIV is echoed by several other authors (Van Wyngaard 2014, van Klinken 2010, Ross 2006).

> The sad legacy of preoccupation with legalism, nominalism, and textual positivism in sacramental theology is the tendency to confuse liturgical worship with rubrics or reduce it to a series of common actions while puritanically policing the boundaries of form and matter. This is a form of distraction at a time when a rapidly secularizing society probes the claim to sanctity of ministers who play mediatory roles and powers in the community called church.…. Proper sacramental performance, it seems to

> me, is judged by the authenticity of justice, depth of mercy, and quality of compassion, not as theological abstractions, but ethical ecclesial praxis. The sacramentality of the world church will flourish or flounder in the measure that it elects to remain faithful to the authentic practices that Jesus instituted as signs of grace and manifestations of the in-breaking of the reign of God into human history—I mean the sacraments of announcing good news to the poor, proclaiming liberty to captives, giving sight to the ignorant, liberating the down-trodden, welcoming the outcast and the unloved…(see Luke 4: 18–19)[26] (Orobator 2012, 20).

The debates and discourses around theologies of natural law and grace, in both Roman Catholic and Protestant circles are complex and there are areas of sharp contrast as well as much overlap. It would be fair to say, perhaps, that much of the tension between a traditional Roman Catholic position on natural law and the authority of the Church and Reformation theology around the role of the church, the work of the Holy Spirit and grace have played out over subsequent decades in a social and political environment characterized by increasing secularism, individualism and liberalism. The Reformation and the Enlightenment set several 'trains in motion' and laid the foundation for a series of important secular and religious trains of thought.

One consequence of this complex set of inter-relationships is the tendency for one group or another to polarize the position of 'the other', which leads to a reductionist discourse, and undermines nuance and pluralism and collaboration. The foundations of the Reformation have fostered within Protestantism an openness to liberal theological approaches, which challenge dogmatic, patriarchal and legalistic interpretations of Scripture and Biblical texts, and have resulted in the rich theological discourse on gender and HIV documented in Chapter 7 as well as to the ordination of women and increasing acceptance of same sex marriage. In the face of hard secularism, the Catholic Churches' pluralistic and trinitarian discourses on gender and sexuality have been

[26] **Luke 4:18-19** The Spirit of the Lord is on me, because he has anointed me to proclaim good news to the poor. He has sent me to proclaim freedom for the prisoners and recovery of sight for the blind, to set the oppressed free, 19 to proclaim the year of the Lord's favour.

minimized in the public square, and at the UN specifically have been characterized by an approach firmly rooted in natural law, and conservative theology on gender and sexuality. The dominance of secularism in the Western and Northern societies has had a reductionist and polarizing effect on public expressions and discussions of a pluralistic theology around grace, rights and responsibilities and sexuality with pressure to remove religion from political debate and reduce faith to a personal and private matter. One effect of this on religious life has been to minimize the role of church in society and increase the search for individual experiences of 'spirituality' among populations in the Western world.

7.3.1.5 HIV as a social justice and human rights issue

James Cochrane, Michael Kelly, Lisa Cahill, Margaret Farley and others explore HIV as a social justice issue (Kelly. 2010, Olivier et al. 2006, Ezra and Sophie 2012). The concept of social justice is an important bridge between theology and the secular concepts of human rights. Kelly highlights the link between inequity and injustice. Inequity becomes injustice when people are denied their inherent right to 'human dignity and the full range of rights accorded by the Universal Declaration of Human Rights' (Kelly. 2010: 17). These inequities and injustices play out at macro and micro levels, often as social determinants of health.

In his 2012 lecture on human rights and religious faith at the WCC in Geneva, Archbishop Rowan Williams stressed the importance of the linkages between the discourses of theology and human rights and called on the faith community to stay engaged in the debate:

> It is important for the language of rights not to lose its anchorage in a universal religious ethic, and just as important for religious believers not to back away from the territory and treat rights language as an essentially secular matter, potentially at odds with the morality and spirituality of believers (Williams 2012).

Gillian Paterson, one of the leading authors on stigma and discrimination in the context of AIDS, co-edited the World Council of Churches Ecumenical Advocacy Alliance publication *Dignity, Freedom and Grace: Christian Perspectives on HIV,*

AIDS and Human Rights, which explores the nexus of faith, human rights, stigma and discrimination, and sexual violence (Paterson and Long 2016). In the introductory chapter to the WCC publication, theologian Julie Clague explores some of the challenges at the intersection of human rights and religious faith. She concludes that human rights are considered by many Christians to be an alternative way of expressing the truths of scripture: ‘To the extent that human rights presuppose the inherent dignity, value and worth of persons, expose unjust social arrangements, and provide a critique of human beings’ inhumanity to other humans, they should be viewed as entirely compatible with Christianity’ (Clague 2016, 6).

Suzette Moses Burton, former Executive Director of the Global Network of People Living with HIV (GNP+), highlights the personal impact of stigma and discrimination in the lives of people living with HIV and the role of faith in generating and sustaining stigma and discrimination. She discusses the value of the stigma index, ‘a research tool to measure stigma and discrimination as experienced by people living with HIV, and to map where it occurs and how it is manifested’ (Burton 2016, 24). The factual information this provides for people living with HIV enables them to advocate for change. This tool has been used by the WCC Ecumenical Advocacy Alliance (EAA) in partnership with UNAIDS to develop a methodology to engage religious leaders in dialogue on stigma and discrimination, using factual data from the stigma index as a starting point for discussion. This has proven to be a powerful tool to shift the dialogue from a theoretical to a very practical one and change the perceptions of religious leaders about the impact of stigmatizing interpretations of the scriptures in the lives of PLHIV.

7.3.1.6 Human sexuality and gender

Theologies around gender inequity and sexuality have been widely explored in the context of HIV by authors including Musa Dube, Manoj Kurian, Fulata Moyo, Ezra Chitando and others in the African Circle. The fact that the AIDS epidemic was first documented among the gay community in the United States led to considerable reflection within the church and theological community on

sexuality, homosexuality and homophobia. Faith communities have often struggled to separate honest discussion of sexuality from moral teaching. The predominant themes of early theology were male-dominated and used to oppress women and typecast men as perpetrators (Dube Shomanah 2009, de Gruchy 2011).

Gerald West finds earlier work exploring the Biblical texts on sexuality to be ambiguous. Biblical texts are used both to support women's empowerment and to reinforce patriarchy and male dominance. He calls for more in-depth work that is careful, not only 'about *what* we interpret them to say to the contexts of HIV and AIDS but also, and more importantly, *how* we interpret them', (italics original) (West 2011, 160).

Steve De Gruchy notes that while theological literature on HIV in the USA in the early 1990s included significant reflection on homosexuality and homophobia, African theology predominantly focused on the heterosexual context of HIV. Gender-based violence and female genital mutilation have been addressed extensively by theologians including Beverley Haddad and Denise Ackermann (de Gruchy 2011, 176-177). This body of literature has shaped the broader religious discourses in powerful ways. It has challenged the ecumenical churches to think differently about the traditionally patriarchal approaches to theology and biblical interpretation that have maintained gender inequality.

Abundant life. The churches and sexuality cites four areas of contestation between religious leaders and secular groups working on SRHR in sub-Saharan Africa identified by Joanne Mantell in 2011. These are (1) the right to sexual autonomy, (2) the right to HIV and AIDS risk-reduction information, (3) the right to reproductive autonomy, and (4) the right to freedom from stigma and sexual-orientation and gender discrimination (Chitando and Njoroge 2016, 2). These areas of contestation are framed not in theological terms, but in rights-based language. Chitando and Njoroge explain however, that SRHR must be translated for faith communities into language that resonates with the 'language and idiom' of religion, as an approach framed exclusively in human rights terms will slow-down progress (Chitando and Njoroge 2016, 3). They point out that many

churches and their leaders are open to transformation, and that preconceived notions that religious leaders are opposed to change should be challenged. The issues of SRHR and religion have been addressed by the African Circle for many years. The Circle has called for a greater celebration of women's sexuality, for women to have autonomy over their bodies and that the historical overemphasis on reproduction should be set aside (Chitando and Njoroge 2016). More recently theological reflection on homosexuality in Africa has been increasing and the African Circle calls on church leaders to approach the issue with the 'sensitivity, creativity and empathy that they mobilized when they responded to HIV and AIDS'. They also call for further research into the issues of HIV and SRHR for publication and teaching (Chitando and Njoroge 2016, 4).

7.3.1.7 Sexual and gender-based violence

Sexual violence is another subject on which there is a large literature both in the secular and theological fields, much of it included in the CHART database (CHART 2011). The UNFPA publication also has a section on violence against women (VAW) (UNFPA 2016, 65). A powerful exchange between UNAIDS Executive Director Michel Sidibé and the then Archbishop of Canterbury Rowan Williams in response to a letter from Violetta Ross, a woman living with HIV from Bolivia addresses some of the critical issues on sexual violence. Violeta wrote to challenge them to address violence against women more effectively. This exchange is illustrative of the broader religious discourse on violence against women and at the same time a challenge to the traditional religio-cultural discourse on its unquestioning promotion for the traditional family without reference to or critique of the potential danger within, such as sexual violence. (Kurian 2016, 72-74).

Michel Sidibé asks:

> For example, can an institution whose leaders are almost always men truly perceive the fears and hear the voices of women at risk of violence? And when it advocates for strong families, can it appreciate that the danger to women and girls often lurks inside their own homes? Do care,

> support and justice extend to women who sell sex or use drugs? Or who are transgendered? Yes. There should be no line that distinguishes between who deserves and who does not (Kurian 2016, 73).

Archbishop Rowan answers:

> What can be done? A lot has already been initiated to challenge the distorted theology that can underlie violent or collusive behaviour. Many churches I know have taken the biblical story of the rape of King David's daughter Tamar as a starting point for rethinking their approach and clarifying the unacceptability of the male behaviour depicted in this and other stories. If we are to make progress here, we have to expose toxic and destructive patterns of masculinity (Kurian 2016, 73).

Archbishop Rowan highlights practical action taken by the 'We Will Speak Out' coalition, which he and Mr. Sidibé launched in 2011 to challenge faith leaders to take this work as a priority.

The broad religious discourse is a movement of theological reflection, biblical interpretation, practical action and advocacy, which spans many faith traditions. The Joint Learning Initiative on Faith and Local Communities learning hub on sexual violence has also commissioned research in this area (le Roux et al. 2016).

7.3.1.8 Transformative masculinities

Adriaan van Klinken reviews the body of theological work on transforming masculinities in the CHART database. Ezra Chitando has led this substantial theological work on masculinities (Chitando and Chirongoma 2012). Klinken highlights that this is a recent development and the literature base is small. Initially gender perspectives focused on women; women being characterized as vulnerable and powerless, and men being characterized as those in power, and the cause of HIV infection in women (van Klinken 2011, 276). Over time, as the concept of masculinity emerged in gender theory, without absolving men of responsibility for sexual behaviour, a more balanced approach to gender

emerged, which recognizes that male behaviour is supported by both men and women. The African Circle invited male theologians to their discussions in 2007. Van Klinken reviews Chitando's discussion of the socialization of men from a social constructionist perspective, which calls for work to examine how negative constructions of masculinity are formed, and how they can be changed (van Klinken 2011, 277). This is explored in detail in the publication, *Redemptive Masculinities* (Chitando and Njoroge 2016, Chitando and Chirongoma 2012).

7.4 Development and debates.

The reader is referred to annex 7 for a discussion of the development and debates on these theological themes, and how they have been influential in the public square can be found in annex 7

7.5 Supporters and strategies

Within the faith community working on HIV there is strong support for this broader religious discourse. This chapter has documented instances where its proponents have brought these discourses to the policy-making arena, in partnership with technical agencies such as UNAIDS and UNFPA. Occasionally religious leaders supportive of broader religious discourse, such as Canon Gideon, are invited to address the UN GA, but these occasions are rare. In general, however, due to the dominance of secularism among MS of the WEOG group, there is no formal mechanism for representatives of this broad religious discourse to influence or to take part in the negotiations on the texts of the PDs on HIV & AIDS.

7.6 Conclusions

The religious discourse on HIV and SRHR is broad, but only a narrow spectrum of this discourse appears at the UN in the negotiations and declarations adopted by MS.

In the broader context of the HIV response alternative religious discourses and approaches are present. These include more progressive religious voices, approaches, theology, practice and advocacy than are found in the PDs on HIV & AIDS; these broader approaches are present across religious traditions and include a much wider range of Catholic perspectives and approaches than are seen in negotiations at the UN.

The broad religious discourses and approaches are supportive of human rights, gender equality and evidence-based approaches to HIV and SRHR.

There is a very broad and large community of religious actors supportive of human rights, gender equality and evidence based public health approaches to HIV and SRHR, which has been active in the HIV response for three decades.

Some of these broader perspectives challenge the interpretation and oppressive ideology of the traditional religio-cultural discourse on human rights, family, HIV and SRHR.

This broader discourse and these perspectives are missing from the negotiations and have no influence on the text of the PDs on HIV & AIDS.

Part B Analysing the discourses in the Political Declarations

The introduction to this thesis explained that the HIV epidemic is a complex interdisciplinary problem: a public health issue, a socio-political issue, a human rights issue, a gender/sexuality issue, and a religious and theological issue and that all of these aspects must be taken into account in order to fully understand and address the HIV epidemic (Smith 2013). To do this an interdisciplinary research methodology is required. Through this approach and methodology an application of critical discourse analysis has identified four distinct discourses operational in the PDs, which have been documented in part A. With reference to the purpose statements and assumptions of this research, also outlined in the chapter 1, part B attempts to demonstrate that the four discourses described in chapters 3-6 are evident in the texts of the four Political Declarations on HIV & AIDS and influence their content. As stated in section 1.3, tension between the discourses is evident in the texts and religion is implicated as a source of that tension.

The methods employed to do this are described in chapter 2 and include a word count and frame mapping of the key words and concepts characteristic of the discourses and an analysis of how some of the key words and concepts are used in the texts. An analysis is conducted of how these words and concepts influence the tone of paragraphs and how the usage of certain key words changes over time. Application of the Verloo template to selected paragraphs is used to draw out the hidden meanings, and sub-texts within the PDs.

The UNAIDS Strategies are identified in chapters 3 and 4 as texts negotiated and adopted by MS, which act as standards, against which the PDs can be compared. Part B compares the PDs against the respective UNAIDS Strategies to identify what is missing from, or compromised in the PDs, and more specifically PD2016.

Selected themes in the discourses identified in part A are tracked through the PDs in part B, to show how the discourses, in particular the traditional religio-cultural and national sovereignty discourses influence themes in the PDs over time. Three themes explored in more detail are: i) the use of the term

'vulnerable', because this is used as a proxy for key populations in earlier PDs and captures some of the elements of the traditional religio-cultural approach to key populations; ii) the factors that put women and girls at increased risk of HIV infection; and iii) how the factors that put young people at increased risk of HIV infection are addressed in the PDs. These thematic case studies draw out ways in which the traditional religio-cultural discourse influences the descriptions and portrayal of women, young people and key populations, and provide examples of how the discourse changes over time.

Part B attempts to answer research questions 2-4 and 6:

- How do the discourses appear and interact in the PDs on HIV & AIDS?
- What topics and issues that appear in UNAIDS strategies are missing from or compromised in the negotiations and the final text of the PDs
- What are some possible explanations for these gaps? Is there a link between what is missing, and the influence of one or more of these discourses?
- Are there ways in which a broader religious discourse including religious approaches that are supportive of public health, human rights and gender equality might help bridge the gaps and bring new insights to the negotiating table?

General Introduction to Political Declarations (PDs)

The PDs follow a similar format. Most begin with a statement of overall political commitment or purpose. These vary according to the level of commitment to the issue among the Member States (MS) represented at the meeting. This is accompanied by acknowledgement of previous PDs, Conventions or key documents relevant to the issue under discussion. This is important because text formally negotiated and adopted by MS forms a precedent for future texts. There follows a series of framing paragraphs, which lay out the problem and describe the different elements of the epidemic to be addressed. Finally, there are a series of paragraphs of commitment to action by MS.

Each of the four PDs on HIV & AIDS contain sections framing the epidemic: reviewing progress and laying out the challenges ahead; providing an overview of the current data; providing a regional perspective; articulating the risks and vulnerabilities faced by populations that the evidence shows to have higher incidence of HIV and its wider negative impacts; articulating the prevention challenge; articulating the treatment challenge; identifying the financial needs, and the human rights and gender equality considerations. Over time, the PDs on AIDS have increased in length, in the nuance and detail of their analysis of the epidemic, and in the strength of commitments. In certain areas, however, there has been no progress in the analysis of issues and in the extent of the commitments. This will be explored in part B.

Part B consists of three chapters:

Discourses and Debates in the Declarations

This chapter attempts to answer research questions 2 and 3. In order to do so, it does four things: It provides an overview of the extent to which each PD reflects the content of the UNAIDS Strategy of the time; it attempts to document how the four discourses appear and interact in the final text of four Political Declarations (PDs). It examines the influence of the traditional religio-cultural discourse on the text of the PDs and it explores what is missing from the text of the PDs. Annexes 8.1, 8.2, 8.3 and 8.4 provide examples of language from UNAIDS Strategies, the equivalent commitment in each PD and some comment or analysis to support the narrative in Chapter 8.

'Vulnerable groups', women and girls, young people and key populations in the PDs

This chapter builds on the evidence and analysis presented in chapter eight. Three case studies focus on i) women and girls, ii) young people, and iii) the use of the terms 'vulnerable groups' and vulnerability. It attempts to address questions of how the traditional religio-cultural discourse influences text of the PDs on women and girls, young people and key populations, for which the term

'vulnerable groups' is a proxy. It also examines how this influence changes over time. Annexes 9.1, 9.2, 9.3 and 9.4 provide examples of text from the PDs and analysis to support the discussion in Chapter 9.

Chapter 10: Analysis, Discussion and Recommendations

Chapter ten addresses research question 6; are there ways in which the broad, bridge-building religious discourse and approaches might bring new insights to the negotiating table to address some of the areas of conflict and tension? In addition, it addresses the question of what strategies are evident in the text of the PDs to address tensions between the discourses. It attempts to draw out areas of potential synergy or common ground between the conceptual frameworks underlying the discourses, from which interdisciplinary understanding is reached and recommendations are offered. Annex 10 provides examples of language included in the 'zero draft' of PD2011 and tracks changes to the text during the negotiations. It also provides analysis of whether the language is strengthened or weakened through the negotiation process to support the discussion in Chapters 9 and 10.

Chapter 8. Discourses and Debates in the declarations

8.1 Introduction

This chapter provides an overview of the four PDs on HIV & AIDS in 2001, 2006, 2011 and 2016 and attempts to do four things:

(a) Assess the extent to which each PD reflects the content of the UNAIDS strategy of the time. This is relevant because the UNAIDS strategy text is negotiated and adopted by Member States (MS) at the UNAIDS Programme Coordinating Board (PCB). Any MS negotiated text is a precedent for future political negotiations and therefore UNAIDS Strategies should provide the blueprint for any PD. They are informed by the most up-to-date data and analysis from UNAIDS and WHO and are negotiated by MS representatives from the health ministries or National AIDS councils. The purpose of this step is to identify what is present and what is missing from the negotiations and the PD texts against a standard.

(b) Document how the four discourses, appear and interact in the final text of the four PDs. Step 2 of the methodology outlined in Chapter 2 was to conduct a frame mapping and identify the number of times selected key words of each discourse appeared in the text. From this word count the dominant discourses in the text are immediately apparent. The graphs in annex 2.2 provides a graphical representation of this mapping. They also provide a visual representation of how the discourses, and the frequency of word use, changes over time.

(c) Visualize the discourses in the PD. Each of the PDs were colour coded, with a colour assigned to each discourse. Using the word search function, I located key words characteristic of each discourse in the PD text and colour-coded the sentences according to the discourse to which it corresponded. This simple technique made it possible to visualize the discourses in the PD. It is possible to see which discourse dominates a paragraph or a section and where there are multiple discourses operating

in a paragraph. These mixed paragraphs are where some of the tensions and conflicts are evident and are the most interesting. This was how paragraphs for closer analysis were selected (see annex 2.1).

(d) Examine the influence of the traditional religio-cultural discourse on the text of the PDs. The frequency of occurrence of terms does not provide information on how those terms are being used in the text. Step 3 involved a close reading of the paragraphs where the traditional religio-cultural discourse appears. This reading compared the elements of the traditional religio-cultural discourse identified in the literature search against the text of the PD, to determine what influence the discourse has on the text. Particular attention was given to paragraphs where the traditional religio-cultural discourse is dominant or influential. One finding to emerge, was that the traditional religio-cultural discourse also had influence on paragraphs where its own key words did not appear, but the overall tone of the paragraph was reflective of the concepts and approach of the discourse. This is discussed in section 8.4.

8.2 Summary of the PDs and comparison with UNAIDS Strategies

Table 8.1. Comparison opening paragraphs of four PDs

PD2001	1. We, heads of State and Government and representatives of States and Governments, assembled at the United Nations, from 25 to 27 June 2001, for the twenty-sixth special session of the General Assembly, convened in accordance with resolution 55/13 of 3 November 2000, **as a matter of urgency**, to **review and address** the problem of HIV/AIDS in all its aspects, as well as **to secure a global commitment** to enhancing coordination and intensification of national, regional and international efforts **to combat it in a comprehensive manner**. 2. **Deeply concerned** that the global HIV/AIDS epidemic, through its **devastating scale and impact**, constitutes a **global emergency** and one of the most **formidable challenges** to human life and dignity, as well as to the effective enjoyment of human rights, which **undermines social and economic development** throughout the world and affects all levels of society – national, community, family and individual;
PD2006	1. We, Heads of State and Government and representatives of States and Governments **participating in** the comprehensive **review of the progress** achieved in realizing the targets set out in the Declaration of Commitment on HIV/AIDS,1 held on 31 May and 1 June 2006, and the High-Level Meeting, held on 2 June 2006; 2**. Note with alarm that** we are facing an **unprecedented human catastrophe;** that a quarter of a century into the pandemic, AIDS has **inflicted immense**

	suffering on countries and communities throughout the world; and that more than 65 million people have been infected with HIV, more than 25 million people have died of AIDS, 15 million children have been orphaned by AIDS and millions more made vulnerable, and 40 million people are currently living with HIV, more than 95 percent of whom live in developing countries;
PD2011	1. We, Heads of State and Government and representatives of States and Governments assembled at the United Nations from 8 to 10 June 2011 to **review progress achieved** in realizing the 2001 Declaration of Commitment on HIV/AIDS1 and the 2006 Political Declaration on HIV/AIDS,2 with a **view to guiding and intensifying** the global response to HIV and AIDS by **promoting continued political commitment** and engagement of leaders in a comprehensive response at the community, local, national, regional and international levels **to halt and reverse the HIV epidemic** and mitigate its impact; 2. **Reaffirm the sovereign rights of Member States**, as enshrined in the Charter of the United Nations, and the need for all countries to implement the commitments and pledges in the present Declaration consistent with national laws, national development priorities and international human rights.
PD2016	1: We, Heads of State and Government and representatives of States and Governments assembled at the United Nations from 8 to 10 June 2016, **reaffirm our commitment to end the AIDS epidemic** by 2030 as **our legacy to present and future generations**, **to accelerate** and scale up the fight against HIV and end AIDS **to reach this target**, and **to seize the new opportunities** provided by the 2030 Agenda for Sustainable Development **to accelerate action** and **to recast our approach** to AIDS given **the potential** of the Sustainable Development Goals to **accelerate joined-up and sustainable** efforts to lead to the end of the AIDS epidemic, and **we pledge to intensify efforts** towards the goal of comprehensive prevention, treatment, care and support programmes that will help to significantly reduce new infections, increase life expectancy and quality of life, the promotion, protection and fulfilment of all human rights and the dignity of all people living with, at risk of, and affected by HIV and AIDS and their families; 2: **Reaffirm the 2001 Declaration of Commitment on HIV/AIDS and the 2006 and 2011 Political Declarations on HIV and AIDS**, and the **urgent need to scale up significantly our efforts** towards the goal of universal access to comprehensive prevention programmes, treatment, care and support;

8.2.1 Political Declaration and UNAIDS Strategy 2001

PD2001 is 103 paragraphs long and is the first PD on a single disease adopted by the UN. It follows the general pattern, structure and content of PDs on other issues.

The UNAIDS Strategy 2001, (hereafter Strategy2001), contains 12 detailed leadership commitments and core actions, addressed to political and other leaders in society, including religious leaders (UNAIDS 2001, iv, 14). These outline all the elements that should be included in the PD. A detailed

comparison of the elements outlined in these 12 leadership and core actions against the commitments of PD2001, 37-93 demonstrate that almost all of the core actions are included (UNAIDS 2001, 14) (General Assembly Resolution 2001, 37-93) (see annex 8.1, which compares PD2001 with Strategy2001).

The political framing in PD2001, 1-8 reflects the emergency caused by the epidemic, expresses 'deep concern' at this 'formidable challenge' and calls for 'global commitment' to comprehensively address it. The purpose is clearly stated: 'as a matter of urgency, to review and address the problem of HIV/AIDS in all its aspects, which is supported later in the document by the latest data. as well as to secure a global commitment to enhancing coordination and intensification of national, regional and international efforts to combat it in a comprehensive manner'(General Assembly Resolution 2001, 1). The framing section of the PD matches well the framing of the UNAIDS strategy, covering the same issues (UNAIDS 2001).

PD2001, 6, includes a clear set of affirmations of previous PDs and other political agreements, which is important. These include reference to the PD and further action initiatives of the Beijing Declaration and Platform for Action (POA) (General Assembly Resolution 1995) and of the International Conference on Population and Development (ICPD) (United Nations 1995b). This is significant because of the strong opposition from supporters of the traditional religio-cultural discourse to concepts of gender and reproductive health at these conferences and the further action initiatives have not been mentioned before (see chapter 5).

PD2001 does not contain a paragraph promoting national sovereignty, national laws and national development priorities over other approaches, which in subsequent years is used to limit the declarations. (A paragraph with this tone appears for the first time in PD2011, 2 and is repeated in PD2016, 4).

Ten paragraphs affirm the importance of strong political leadership, starting with three introductory leadership statements: (General Assembly Resolution 2001, 36-46).

Strong leadership at all levels of society is essential for an effective response to the epidemic.
Leadership by Governments in combating HIV/AIDS is essential and their efforts should be complemented by the full and active participation of civil society, the business community and the private sector.
Leadership involves personal commitment and concrete actions (General Assembly Resolution 2001) (italics original).

In PD2001, 37-93, the commitments reflect all the elements listed in the 12 leadership and core actions statements of Strategy2001 (UNAIDS 2001, 14) Annex 8.1 demonstrates a number of specific areas where PD2001 does not go as far as Strategy2001, and this pattern of reduced specificity, qualifications and omissions is followed in subsequent PDs. Commitment 7 of Strategy2001 lists and names each of the key populations. It calls specifically for strengthening of legal, policy and programmatic action to address the vulnerability of children and key populations. In addition, it recommends HIV education for young people, calling for life-skills education and a more open discussion of sexuality. These elements are all missing from PD2001, which does not name key populations, but refers to them as 'identifiable groups' (General Assembly Resolution 2001, 48). The reference to strengthened legal frameworks refers only to the workplace (UNAIDS 2001, 69).

8.2.2 Political Declaration and UNAIDS Strategy 2006

PD2006 is noteworthy for its simplicity and brevity. There is little evidence of the ideological conflicts evident in PD2001, PD2011 and PD2016. Containing 41 paragraphs, it is the shortest of the PDs. The political framing is perfunctory; its purpose to 'review progress' in achieving the targets set in PD2001 (General Assembly Resolution 2006, 1) (see table 8.1). Framed as a staging post, the declaration breaks new ground in advancing the concept of universal access to HIV prevention, treatment care and support services, but limits the commitment with the phrase 'to scale up significantly towards the goal' (General Assembly Resolution 2006, 49)

In 2005, UNAIDS adopted the UN System Strategic Framework on HIV and AIDS 2006–2010 (henceforth Strategy2006) (UNAIDS 2005). Its focus is to strengthen the UN System response to achieve the goals and targets of the MDGs and PD2001, but many of the objectives and outputs are directed at countries, this document therefore provided the blue-print for PD2006. It lists eight principles underpinning the strategic framework, all of which are reflected in the commitments of PD2006. It also provides eight objectives and outputs including to name the key populations and to call for up to date sex and age-disaggregated data (UNAIDS 2005, 5, 14). PD2006 is missing any reference to key populations or disaggregated data.

PD2006 includes one paragraph on each of the major issues in the framing section. The political framing refers to PD2001 and the ICPD goal of achieving 'universal access to reproductive health by 2015' (General Assembly Resolution 2006, 18). The framing paragraphs are consistent in style; each describing the problem or affirming a strategy essential to a successful HIV response. The commitments follow, in line with the perfunctory and factual framing and include all but two of Strategy2006 outputs (see annex 8.2, which provides a comparative analysis of Strategy2006 vs PD2006).

PD2006, 22-27 political leadership and commitments start with a re-affirmation of commitment to PD2001, the goals and targets of the MDGs, and the goal of 'achieving universal access to reproductive health by 2015' at the ICPD. The main commitment made by PD2006 is to achieve 'Universal access to comprehensive HIV prevention, treatment, care and support by 2010' (General Assembly Resolution 2006, 3).

8.2.3 Political Declaration and UNAIDS Strategy 2011

Getting to Zero 2011-2015 Strategy Joint United Nations Programme on HIV & AIDS (UNAIDS) (hereafter Strategy2011) contains three strategic directions and 10 goals (UNAIDS 2011c, 7), which provide a standard against which PD2011can be compared.

PD2011 is the most highly charged of the declarations in terms of ideological conflict between the discourses. This can be clearly seen in the sample colour coded paragraphs in annex 2.1. 105 paragraphs long, the tone is set in the second paragraph, with a strong statement on national sovereignty (General Assembly Resolution 2011, 2) (see table 8.1). This precedes any affirmation of the previous PDs on HIV & AIDS. The message is clear from the start: national laws and development priorities come before international human rights and other international agreements.

PD2011 reaffirms the two previous PDs on HIV & AIDS. Its stated aim is to achieve 'universal access to comprehensive prevention programmes, treatment, care and support'. To achieve this aim, nine paragraphs of political leadership commitments PD2011, 49-57 include the strongest political commitment so far, 'to end the epidemic'. The commitments however, do not go far enough in identifying the specific details of what actions are needed to end the epidemic. (General Assembly Resolution 2011, 3, 8, 49) (see annex 8.3, which provides a comparative analysis of Strategy2011 vs PD 2011).

PD2011's strength lies in its inclusion of historic, numeric, time-bound targets. The commitments however are frequently 'qualified' or 'limited' by terms such as 'working towards', or 'as appropriate'. For example: PD2011, 62 includes the Strategy2011 goal of reducing sexual transmission of HIV by half, but is qualified by 'working towards', and does not name key populations. Similarly, the Strategy2011 goal that 'Vertical transmission of HIV is eliminated, and AIDS related maternal mortality reduced by half', is found in PD2011, 64, but using 'mother-to-child' terminology, rather than vertical transmission. The goal for people who 'use drugs' is modified to people who 'inject drugs', and the qualification 'in accordance with national legislation' added in PD2011, 59. Strategy2011 goal 'Countries with punitive laws and practices around HIV transmission, sex work, drug use or homosexuality that block effective responses reduced by half' is qualified twice, with 'as appropriate' and 'in accordance with relevant national review frameworks and time-frames' in PD2011, 59h. However, on women and girls PD2011, 81 is stronger and more specific than Strategy2011. The UNAIDS goal reads 'HIV-specific needs of women and girls are

addressed in at least half of all national HIV responses'. PD2011, 81 commits 'to ensuring that national responses to HIV and AIDS meet the specific needs of women and girls', strengthening the target from half to all. Finally, on punitive laws Strategy2011 goal reads 'Countries with punitive laws and practices around HIV transmission, sex work, drug use or homosexuality that block effective responses reduced by half'. In PD2011, 78 the commitment is qualified twice, and the language is toned down from 'punitive laws & practices' to 'laws and policies that adversely affect …'. Strategy2011 is more specific than PD2011. (General Assembly Resolution 2011, 62, 64, 59, 78, 81) (UNAIDS 2011c, 7) (see annex 8.3 for analysis and text).

PD2011, 2, 29, 55 and 59 all state the importance of countries defining their epidemics according to their national priorities and local epidemiological and social circumstances, yet provide no substantive analysis of why specific, targeted interventions are needed in different countries, or what these differentiated approaches should look like. As a result, PD2011 is limited in its potential to articulate a clear way forward for countries that is based on solid analysis of their distinctive epidemiological drivers and key populations. PD2011 does not draw sufficiently on Strategy2011 to ensure that it is a political plan of action informed by the best data and analysis. The UNAIDS and WHO strategies are only referenced briefly at the very end of the framing section (General Assembly Resolution 2011, 47) (see annex 8.3 for analysis and text).

8.2.4 Political Declaration and UNAIDS Strategy 2016

PD2016, comprising 151 paragraphs, is the most recent and the strongest of all the PDs as analysis in annex 8.4 shows. It remains limited in some important areas (discussed below and in annex 8.4) but provides the most integrated and coherent presentation of the HIV epidemic and response of the four PDs, as it demonstrates learning from the process of negotiation, and clarity of language in the Sustainable Development Goals (SDGs), which themselves make linkages for example between health outcomes for women and children and gender equality, economic empowerment and freedom from violence. This is most apparent in the strength of the sections on women and girls. Strategies developed during

these negotiations resulted in SDG 5 on gender equality (General Assembly Resolution 2015, 14/35).

Strategy2016 outlines three goals and 10 targets (see chapter 3 and annex 3) (UNAIDS 2015c, 8, 15). This next section will compare these with the goals and targets that appear in PD2016. What is clear from this comparison is that goals and targets relating to women and children are generally strengthened, whereas goals and targets relating to young people, key populations and on HIV prevention are compromised by qualifying words or phrases (see annex 8.4 for examples of text and analysis).

The three numerical goals from Strategy2016 are included in PD2016, 56, but qualified by the term 'working towards'. PD2016, 60a commits to target 1 and strengthens the commitment towards children, specifying a treatment target by 2018, with 'special emphasis on providing 1.6 million children with antiretroviral therapy by 2018'. PD2016, 65 a-d, strengthens target 1 further by articulating a series of specific targets for each geographic region. Target 2 to eliminate new infections among children, keeping mothers alive and well, is also strengthened with detail on providing lifelong HIV treatment for mothers in PD2016, 60c. However, target 3 that '90 percent of young people are empowered with the skills, knowledge and capability to protect themselves from HIV', is not reflected in full. PD2016, 62c, commits to 'accelerate efforts to scale up scientifically accurate age-appropriate comprehensive education', and is compromised by the phrases 'relevant to cultural contexts', 'consistent with their evolving capacities', and 'to enable them to build self-esteem, informed decision-making, communication and risk reduction skills and develop respectful relationships'. Target 4, on access to 'combination HIV prevention' and SRH services, is compromised by the substitution of the term 'comprehensive prevention programmes' in PD2016, 62a-b. This is because the term combination prevention is carefully defined by UNAIDS and includes a specific set of actions. Comprehensive HIV prevention, however is un-defined and therefore does not necessarily include all actions necessary for HIV prevention among key populations (UNAIDS 2016d, 10). Target 5, that 27 million men are voluntarily medically circumcised is modified to 25 million by 2020, as an interim target in

PD2016, 62f. Target 6, '90 percent of key populations, including sex workers, men who have sex with men, people who inject drugs, transgender people and prisoners, as well as migrants, have access to HIV combination prevention services', is also modified in PD2016, 62f to 'comprehensive HIV prevention'. Key populations are not named but covered by the term 'those at risk of HIV infection'. Targets 7, 8, 9 and 10 are reflected in PD2016, 61c, 63d, 59b, and 62i (General Assembly Resolution 2016, 59, 59b, 60a-c, 61c, 62a,b,f, 63d, 65a-d) (see annex 8.4 for text, comparison and analysis).

To achieve these goals and targets the opening paragraph and political framing of PD2016 use the strongest language of all PDs (see table 8.1). The political purpose is 'to reaffirm our commitment to end the AIDS epidemic by 2030 as our legacy to present and future generations' (General Assembly Resolution 2016, 1).

PD2016, 2, 3 reaffirm previous PDs and the SDGs. Paragraph 4, on national sovereignty, is worded identically to PD2011. It does not appear as dominant in PD2016 as it did in PD2011 however as the tone has already been set in paragraphs 1-3 with language that is, positive and takes responsibility, characteristic of forward looking political discourse as opposed to neutral or the limiting, fearful and guarded language, more characteristic of the national sovereignty discourse (compare the words highlighted in **bold** in table 8.1)

PD2016, 5 reaffirms a long list of Conventions and Declarations, but the list is stronger than in 2001, because, unlike the previous PDs, the outcome documents of the review conferences from Beijing and the ICPDs are referenced and affirmed, as are the Convention on the Rights of Persons with Disabilities, and- for the first time in a PD on HIV & AIDS- the Convention on the Elimination of Discrimination against Women. This paragraph notes the specificity of the outcome documents from the regional reviews of these meetings and the specific packages of guidance on population and development for each region contained therein (General Assembly Resolution 2016, 5). Reference to these documents is significant and major step forward for the human rights and gender discourse, because the conflict with traditional religio-cultural discourse around gender, sexual and reproductive health and rights has spilled over from the first

ICPD and Beijing conferences into negotiations on HIV since the beginning of the epidemic and compromised effective language and responses for women, girls and key populations in PDs on HIV & AIDS. The inclusion of the term reproductive rights occurs for the first time in a PD on HIV & AIDS in PD2016, whilst the document does not go as far as Strategy2016, which calls for sexual and reproductive health and rights (see annex 8.4 for full analysis).[27]

The general framing section, PD2016, 7-13, continues in similar vein, affirming the UDHR, international collaboration, the SDGs and the importance of addressing inequality. Re-introduction of the term 'dignity', and the call for a 'virtuous cycle' of progress in PD2016 are noteworthy as they may demonstrate the beginnings of a re-claiming of religious language from the traditional discourse by a public health and rights-based constituency, which began to take place through the negotiations towards the SDGs (General Assembly Resolution 2016, 1, 10).

With regard to human rights, the Strategy2016 reference to punitive laws is also missing from PD2016, and replaced with qualifying terms: 'laws which exclude' and 'laws which restrict' (General Assembly Resolution 2016, 39, 46).

Stratgegy2016 core actions to strengthen community engagement are largely met in PD2016, including to strengthen community systems, provide community based HIV testing, increase community-led service delivery to 30% and increase

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[27] **Reproductive rights** "embrace certain human rights that are already recognized in national laws, international human rights documents and other consensus documents. These rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. It also includes their right to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human rights documents. In the exercise of this right, they should take into account the needs of their living and future children and their responsibilities towards the community."

Sexual rights embrace a "human right that already are recognized in many national laws, international human rights documents and other consensus statements: the right of all persons to the highest attainable standard of sexual health, free of coercion, discrimination and violence. This includes the following: accessing sexual and reproductive health-care services; seeking, receiving and imparting information related to sexuality; obtaining sexuality education; enjoying respect for bodily integrity; choosing a partner; deciding to be sexually active or not; participating in consensual sexual relations; engaging in consensual marriage; determining whether or not (and when) to have children; and pursuing a satisfying, safe and pleasurable sexual life" (UNAIDS 2015d, 39, 42)

resourcing for advocacy services through local communities including to 'ensure at least 6% of all global AIDS resources are allocated for social enablers including advocacy, community and political mobilization' (General Assembly Resolution 2016, 14, 29, 60b,d,h, 64a).

8.3 How do discourses appear and interact in the PDs?

Discourses can be identified by the frequency of references to the key words and concepts of the discourse in the text. There are paragraphs and sections within the text where one of the discourses is clearly dominant.

As declarations of action on an epidemic, the public health and biomedical discourse dominates all four PDs. Words characteristic of this framing are numerous and appear with greater frequency than words of the other discourses, as demonstrated in the graphs in annex 2.2 Some of the public health and biomedical words appear between 20 and 80 times in one PD (e.g. health, prevention, treatment, epidemic). In each of the PDs there are sections on HIV prevention, treatment, care and support, which contain significant detail on the public health measures needed to achieve the goals and targets. PD2016, 60 a-h provides a good example of a series of detailed biomedical paragraphs on scaling up HIV testing and treatment (see annex 8.4).

The second most dominant discourse is human rights and gender. Significant key words associated with this discourse generally appear between 5 and 20 times, with a jump in number of references to human rights (to 33) and women (to 64) in PD2016. In PD2016, there are also increases in references to sexual and reproductive health, populations at higher risk of HIV infection, and violence, including sexual violence, but no significant increase in references to men and boys or key populations. PD2016, 61a-o) is an example of a section of commitments on women and girls. The human rights and gender discourse is dominant in these paragraphs, interspersed with a few paragraphs where the public health discourse is dominant e.g. PD2016, 61j.

Words characteristic of the traditional religio-cultural discourse and the national sovereignty discourses appear much less frequently (generally below 10). The text of PD2001 and PD2011 include the most references to words and concepts characteristic of the traditional religio-cultural discourse. Annex 2.2 shows that the word 'family' occurs frequently in both PD2001 and PD2011, 15 and 18 times respectively. As discussed in Chapter 5, the traditional family is a central concept to the traditional religio-cultural discourse.

PD2011, 2, repeated in PD2016, 4, and is an example of a paragraph where the national sovereignty discourse is dominant (See table 8.1). Phrases from this paragraph are repeated in other paragraphs, sometimes together with phrases from the traditional religio-cultural discourse in order to limit content in the PDs.

PD2011, 43 contains similar language to PD2001 20, and 31 in which the traditional religio-cultural discourse is dominant:

> Reaffirm the central role of the family, bearing in mind that in different cultural, social and political systems various forms of the family exist, in reducing vulnerability to HIV, inter alia in educating and guiding children, and take account of cultural, religious and ethical factors in reducing the vulnerability of children and young people… (General Assembly Resolution 2011, 43).

Words and phrases characteristic of the traditional religio-cultural discourse are inserted into paragraphs on HIV, prevention and human rights to limit, compromise or qualify the proposed action. Examples of this are discussed in the next section. Examples of how tension between the discourses can be seen in colour coded paragraphs can be found in annex 2.1.

8.3.1 Interaction of the discourses in the PDs

Most paragraphs of the four political declarations have one dominant discourse throughout the paragraph, generally undisturbed by other discourses.

In each of the PDs, paragraphs are clustered according to themes. Substantial sections of the texts discuss HIV prevention and treatment. These paragraphs are predominantly framed using a public health discourse (e.g. PD2011, 33, 66 and 67; PD2016, 34 and 60 a-i).

The sections on human rights also include paragraphs on women, girls and gender equality. These paragraphs are framed through the biomedical and human rights and gender equality lenses (e.g. PD2016, 33 and 61a-e). It is clear that the public health, biomedical, and human rights, gender equality discourses work together and frequently appear together in paragraphs and sections (e.g. PD2016 10, 14, 15, 21, 44 and 47).

Political commitment and national sovereignty discourses are prominent in all PDs. Some paragraphs express strong political commitment (e.g. PD2016, 1, table 8.1). Others express national leadership and ownership (e.g. PD2016, 57).[28] Some focus on national sovereignty (e.g. PD2011, 2, repeated in PD2016, 4,) which is more limiting in nature. A few paragraphs are framed solely in terms of a traditional religio-cultural discourse (e.g. PD2001, 63, see annex 8.1, repeated in PD2011, 43).

In some paragraphs several discourses are present; this clustering of discourses can easily be seen by colour coding the text of the PD. The public health, biomedical discourse appears with the human rights and gender discourse in PD2016, 44 and 47. The traditional religio-cultural discourse appears together with the national sovereignty, public health and human rights and gender discourses in PD2011, 20. Some paragraphs include a mixture of discourses with no apparent conflict or competition between them. In these paragraphs the mix of issues is complementary; it draws out the multifaceted nature of the AIDS

[28] PD2016, 57: Commit to differentiate HIV responses, based on country ownership and leadership, local priorities, drivers, vulnerabilities, aggravating factors, the populations that are affected and strategic information and evidence, and to set ambitious quantitative targets, where appropriate depending on epidemiological and social context, tailored to national circumstances in support of these goals

epidemic and the need for a multi-sectoral response (e.g. PD2001, 27) (see chapter 2 and annex 2.1).

In some paragraphs however, the discourses are in tension with one another. For the purposes of this study, these paragraphs are the most interesting. This phenomenon occurs in both framing and commitment paragraphs. The traditional religio-cultural discourse and national sovereignty discourse limit public health and rights-based approaches to HIV prevention in PD2011, 59 and 59h (see annex 8.3) and compromise human rights statements in PD2011, 38. A traditional religio-cultural discourse limits PD2016, 62c on public health and gender (see annex 8.4). Such tensions are less evident in sections about treatment, women and girls, and children.

8.4 How the traditional religio-cultural discourse influences the PDs

This section will explore how the traditional religio-cultural discourse appears in the PDs, influences them, and changes over time. Three methods are applied in this section, first a word count to identify the frequency of references to key words characteristic of the discourse. Second a close reading of the text, to examine how the words, phrases and concepts are being used in the text, and third application of the Verloo template of questions to selected paragraphs to draw out the hidden meanings or sub-text in the paragraph.

In chapter 5 words and phrases characteristic of concepts within the traditional religio-cultural discourse are listed and discussed. Concepts include the importance of the family and responsibility of parents in educating children, promoting abstinence and faithfulness as methods of HIV prevention, reducing risk-taking behaviour and encouraging responsible sexual behaviour, the importance of addressing gender inequality in ways that are respectful of cultures, and the concept of vulnerability. These concepts are all established in PD2001 (General Assembly Resolution 2001, 31, 52, 60, 63).

8.4.1 Traditional religio-cultural discourse in PD2001

PD2001 contains the most references (27) to the term vulnerability of all the PDs. This term is strongly associated with the traditional religio-cultural discourse as a proxy term for key populations. PD2001 contains the most references to the terms ethic/al (5), culture/al (8) and responsibility (3) of all the PDs. Abstinence and faithfulness are each mentioned once.

The traditional religio-cultural discourse is most apparent in paragraphs 20 and 63. In PD2001, 20, it is combined with the national sovereignty discourse: ‘Emphasizing the important role of cultural, family, ethical and religious factors in the prevention of the epidemic and in treatment, care and support, taking into account the particularities of each country as well as the importance of respecting all human rights and fundamental freedoms’. Immediately following this, PD2001, 21 points out the ‘negative economic, social, cultural, political, financial and legal factors’ that ‘hamper’ the HIV response (General Assembly Resolution 2001, 20, 21). These two paragraphs together demonstrate the tension between the discourses. The traditional religio-cultural and national sovereignty discourse supporters seek to establish the importance of family and religion as central factors in HIV prevention in PD2001, 20.[29] As explained in chapter 5, the traditional discourse does not consider the possibility that culture and families can be abusive. PD2001, 21, inserted by the public health, human rights and gender equality supporters, immediately makes the point that culture and family can hamper the HIV response.[30]

PD 2001, 63 (see annex 8.1) is one of the strongest examples of language characteristic of the traditional religio-cultural discourse across the PDs. It is repeated in slightly modified form in PD2011, 43. It seeks to provide families with influence over the planning, implementation and evaluation of biomedical and rights-based HIV & AIDS prevention and care programmes. To examine this,

[29] PD 2001, 20. Emphasizing the important role of cultural, family, ethical and religious factors in the prevention of the epidemic and in treatment, care and support, taking into account the particularities of each country as well as the importance of respecting all human rights and fundamental freedoms;

[30] PD2001, 21. Noting with concern that some negative economic, social, cultural, political, financial and legal factors are hampering awareness, education, prevention, care, treatment and support efforts;

PD2001, 63 was interrogated using the 'super text template' of sensitizing questions designed by Verloo et. al. (Verloo 2016, 30).

Analysis shows that the central concepts of this paragraph are the importance of the family, and cultural, religious and ethical factors in reducing vulnerability to HIV. The origins of the concept of family as central to society and the rights of parents to decide on the form of education for their children can be traced back to the UDHR (General Assembly Resolution 1948, 16.3, 26.3). Whilst the activities listed are primarily the responsibilities of the state to provide, the paragraph places the family (informed by religion, culture and ethics) as the main actor. The problem is represented as the vulnerability of children and young people to HIV infection. By implication this is because cultural, religious and ethical factors are not taken into account in actions to reduce the vulnerability of children and young people to HIV infection, and environments are not safe and secure. The solutions are to strengthen policies and programmes which recognize the central role of the family, and to provide more youth friendly information, sexual health education and counselling services in HIV and AIDS prevention and care programmes that families and young people are involved in planning, implementing and evaluating.

Many supporters of the public health, human rights and gender equality discourses also recognise the importance of family and parenting. The challenge arises when these concepts are invoked in order to limit, restrict or challenge evidence and rights-based approaches to HIV prevention and education. PD2001 63 calls for families to be involved in the planning, implementation and evaluation of a wide range of programmatic areas which are the primary responsibility of the state to provide: e.g. primary and secondary education, HIV curricula, safe environments, strengthening SRH programmes. The advice of parents is important, but there is no affirmation in the paragraph of the central role of the state in providing these services, nor any recognition of the possibility that families, culture and religion can increase vulnerability or be harmful and damaging.

This approach of asserting recommendations as ‘given’, without supporting evidence or recognition of the counter-factual, is characteristic of the traditional discourse, which refers to ‘natural law’ as its authority (see Chapter 5) (Catholic Church 1997b). The traditional religio-cultural discourse is characterized by this approach of irrefutability.

This is of particular concern when religious communities and families promote conservative approaches to HIV education including abstinence-only programmes or deny information on HIV and SRH to young people. Evidence shows that funding for abstinence-only programmes has failed to reduce HIV incidence rates (Lo, Lowe, and Bendavid 2016). Another concern is that some religious communities exert pressure on national authorities to criminalise behaviours that contravene their faith teaching. These laws can limit access to health services for key populations.

The Verloo method helps to draw out some of these nuances from the textual analysis. The tension and the ideological approaches to these discourses become much clearer at the UN during negotiations and in the interventions presented by MS following the adoption of the PD.

8.4.2 Traditional religio-cultural discourse in PD2006

In PD2006 the word religion does not appear, however, the term culture performs the same role. Ethics and culture are used, as in the other PDs, to limit paragraphs on HIV prevention. For example, PD2006, 22 contains several elements of a traditional religio-cultural discourse. It states that prevention programmes must take account of local ethics and cultural values, and advocates the inclusion of ‘information, education and communication, in languages most understood by communities and respectful of cultures, aimed at reducing risk-taking behaviours and encouraging responsible sexual behaviour, including abstinence and fidelity’ (General Assembly Resolution 2006, 22).

PD2006 refers to family once, culture twice, abstinence and faithfulness once, responsibility twice, ethical once, and vulnerable seven times. Of the framing

paragraphs, eight (2-4, 8-10, 12 &14) lead with a biomedical framing and three, with a human rights and gender framing (paragraphs 7,11 and 13). The traditional religio-cultural discourse appears in muted form in PD2006, but neither this nor the national sovereignty discourse influences the text significantly.

8.4.3 Traditional religio-cultural discourse in PD2011

PD2011 contains the strongest evidence of a traditional religio-cultural discourse. This is apparent in the frequency of appearance of key words and concepts associated with the discourse, and through the tensions evident in the negotiations. References to family increase from 1 in PD2006, to 18 in PD2011. The terms marriage, moral, and spiritual are introduced. References to parents, religion, faith, and responsibility are maintained. An additional reference to abstinence and faithfulness is introduced. PD2011, 43 contains almost the same wording as PD2001, 63 and this language is the strongest example of traditional religio-cultural discourse across all the PDs. It seeks to influence the planning, implementation and evaluation of biomedical and rights-based HIV and AIDS prevention and care programmes (General Assembly Resolution 2011, 43). The influence of the traditional religio-cultural discourse on other paragraphs in PD2011 is drawn out further in section 8.4.5, which summarizes and discusses the traditional religio-cultural discourse across all the PDs.

8.4.4 Traditional religio-cultural discourse in PD2016

In PD2016, the key words and concepts characteristic of the traditional religio-cultural discourse are still evident, but much reduced (see annex 2.2). There are just seven references to families. References to religion, spiritual, moral, values, abstinence and faithfulness are absent. There is just one reference to responsible. The number of references to parents is increased, though not all have the effect of limiting interventions. One of these references refers to the death of a parent (paragraph 40), one to providing ‘comprehensive education’ to young people in partnership with parents (paragraph 62c), and the third is to ‘bear in mind the roles and responsibilities of parents’ (PD2016, 64a). PD2016,

62c contains the term cultural, which is used to qualify comprehensive HIV prevention education for young people, but the overall tone of the paragraph is less constricting and there is more nuance in the framing of the issues (General Assembly Resolution 2016, 62c).

8.4.5 Summary and discussion of the traditional religio-cultural discourse across the PDs

Bringing the detailed analysis from the above sections together, the traditional religio-cultural discourse is present in all four PDs on HIV & AIDS. It manifests in five ways:

- Simply as a constituency or set of issues pertinent to the response. In these instances there is no ideological weight behind the reference to traditional, religio-cultural issues mentioned; their inclusion is entirely appropriate. These references are few and generally appear as part of a list. For example the reference to spiritual care, in PD2011, 69.[31]
- To limit or restrict public health and biomedical and rights-based approaches to HIV prevention and SRHR, e.g. PD2006, 22 (General Assembly Resolution 2006) (see annex 8.2).
- To influence the tone of some paragraphs and frame issues or groups in line with the framing of a traditional discourse. For example, women are framed in some paragraphs as passive, as victims, without agency to exercise their rights, primarily as home-makers and care-givers (e.g. PD2011 21).[32] The international drug problem is framed as a serious and

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[31] Commit to promote services that integrate prevention, treatment and care of co-occurring conditions, including tuberculosis and hepatitis, improve access to quality, affordable primary health care, comprehensive care and support services, including those which address physical, spiritual, psychosocial, socio-economic, and legal aspects of living with HIV, and palliative care services (General Assembly Resolution 2011, 69)

[32] Remain deeply concerned that globally women and girls are still the most affected by the epidemic and that they bear a disproportionate share of the caregiving burden, and that the ability of women and girls to protect themselves from HIV continues to be compromised by physiological factors, gender inequalities,
including unequal legal, economic and social status, insufficient access to health care and services, including for sexual and reproductive health, and all forms of discrimination and violence, including sexual violence and exploitation against them (General Assembly Resolution 2011, 21);

alarming threat.[33] To exclude the naming and limit the framing of problems and specific commitments to action, for key population groups (see annex 8.3).

- To limit or exclude text on issues, which are not consistent with the traditional discourse (e.g. comprehensive sexuality education). This is evidenced by their absence in the text, and by interventions from member states following adoption of the PD, stating their objections to them (see annex 8.4).

8.4.5.1 Limitation or restriction of public health and biomedical and rights-based approaches

The traditional religio-cultural discourse restricts evidence-based and rights-based approaches to HIV prevention and SRHR in two ways. Firstly, by providing a statement which counters, or qualifies the initial public health or human rights-based assertion in a limiting way. This is seen in PD2011, 38, 59, 59 a-d, where the text clearly switches back and forth between strong rights and evidence-based phrases and traditional religio-cultural discourse or national sovereignty phrases (see annex 2.2).

The second approach is to substitute an alternative weaker term. For example, 'combination HIV prevention' is specifically defined by UNAIDS (UNAIDS 2016d, 10) but is not included uniformly in PD2016. In some places it is replaced with the undefined term 'comprehensive HIV prevention' (General Assembly Resolution 2016, 60), which provides a loophole for countries to select an approach in line with religion and culture, that is selective in terms of populations served and is not necessarily in line with human rights, scientific evidence and combination HIV prevention (see annex 8.4).

[33] Note with alarm the rise in the incidence of HIV among people who inject drugs and that, despite continuing increased efforts by all relevant stakeholders, the drug problem continues to constitute a serious threat to, among other things, public health and safety and the well-being of humanity, in particular children and young people and their families, and recognize that much more needs to be done to effectively combat the world drug problem (General Assembly Resolution 2011, 26);

8.4.5.2 To influence the tone of a paragraph

The traditional religio-cultural discourse influences the tone of some paragraphs to frame either issues, or population groups in line with the traditional discourse. This is particularly evident in texts discussing women and girls and is explored further in chapter 9. One example of this is in the framing of the international drug problem in the PD2011, 26:

> Note with alarm the rise in the incidence of HIV among people who inject drugs and that, despite continuing increased efforts by all relevant stakeholders, the drug problem continues to constitute a serious threat to, among other things, public health and safety and the well-being of humanity, in particular children and young people and their families, and recognize that much more needs to be done to effectively combat the world drug problem (General Assembly Resolution 2016, 26)

In this paragraph, the problem is not framed in objective, neutral or public health and human rights terms, as it is in PD2016, 43:

> Note that some countries and regions have made significant progress in expanding health-related risk and harm reduction programmes, in accordance with national legislation, as well as antiretroviral therapy and other relevant interventions that prevent the transmission of HIV, viral hepatitis and other blood-borne diseases associated with drug use… and calls attention to… the marginalization and discrimination against people who use drugs through the application of restrictive laws, particularly those who inject drugs which hamper access to HIV-related services, and in that regard, consider ensuring access to such interventions including in treatment and outreach services, prisons and other custodial settings, and promoting in that regard the use, as appropriate, of the WHO, UNODC and UNAIDS Technical Guide for Countries to Set Targets for Universal Access to HIV Prevention, Treatment and Care for Injecting Drug Users...(General Assembly Resolution 2016, 43).

In PD2011, 26, drug use is framed as a problem which cannot be solved, despite the best efforts of all stakeholders and which poses a great threat to families and children. The tone of the paragraph is one of fear, and the focus is on the family and children, rather than the HIV epidemic and the people who are infected with HIV as a result of sharing needles to inject drugs. This tone is characteristic of the traditional religio-cultural discourse as outlined in Chapter 5. The tone of PD2016, 43, by contrast, is more neutral and factual.

8.5 What is missing from the negotiations and PDs when compared to the respective UNAIDS Strategies?

8.5.1 References to Key populations

The PDs do not systematically name key populations most at risk of HIV infection or frame the factors that put each specific group at risk. Commitments to action for key population groups are generic and lack any disaggregation by specific key population.

Annex 2.2 illustrates how, in PD2016, there is a very significant increase in references to women and girls compared with PD2011. Closer analysis demonstrates that, in PD2016, there is detailed framing of the factors, including the social and structural determinants that increase HIV infection among women and girls (PD2016, 15,16, 18, 33, 38, 39, 41, 42,43, 45) and a corresponding set of specific commitments to address these issues (PD2016, 61 a-o). This is because, as the PDs become stronger over time, the nature, depth of analysis, nuance and language used in the framing of an issue in the first half of a PD becomes stronger. This is reflected in greater strength of language in the commitments section which follows. Stronger analysis and framing generally leads to stronger, more specific commitments. Both framing and commitments increase in nuance and specificity over time.

Annex 2.2 also shows that in PD2016 there is no corresponding increase in paragraphs framing the specific social and structural determinants that put key populations at increased risk of HIV infection. The texts of all four PDs are

missing both a comprehensive framing of the needs of, and risks of HIV infection to, sex workers, men who have sex with men, transgender people and prisoners (broken down by key population), and commitments towards specific measures to address the epidemics in each of these population groups. The disproportionately high levels of HIV infection among these groups are highlighted in PD2016, 42 which states:

> Note with alarm the slow progress in reducing new infections and limited scale of combination prevention programmes, emphasizing that each country should define the specific populations that are key to its epidemic and response based on the local epidemiological context, and note with grave concern that women and adolescent girls, in particular in sub-Saharan Africa are more than twice as likely to become HIV positive than boys of the same age, and noting also that many national HIV-prevention, testing and treatment programmes provide insufficient access to services for women and adolescent girls, migrants, and key populations that epidemiological evidence shows are globally at higher risk of HIV, specifically people who inject drugs, who are 24 times more likely to acquire HIV than adults in the general population, sex workers, who are 10 times more likely to acquire HIV, men who have sex with men, who are 24 times more likely to acquire HIV, transgender people, who are 49 times more likely to be living with HIV, and prisoners, who are five times more likely to be living with HIV than adults in the general population (General Assembly Resolution 2016, 42).

The corresponding commitment to action comes in PD2016, 60e. It is short and perfunctory and notably does not use the fully defined term 'combination prevention':

> Promote the development of and access to tailored HIV comprehensive prevention services for all women and adolescent girls, migrants, and key populations (General Assembly Resolution 2016, 60e).

PD2016, 42 is the most detailed paragraph in any of the PDs on key populations, and specific data is given on their increased risk of HIV infection. However, the paragraph also states that countries should be able to define populations at risk in line with their national context. The avoidance of naming and providing specific details of the needs and actions necessary to address the increased risks and impacts of HIV infection in key populations is reflective of the national sovereignty discourse supported by the traditional religio-cultural discourse, as previously discussed.

PD2016, 42 positions the increased risk of HIV infection to women and girls in sub-Saharan Africa before the needs of key populations. HIV infection among women and girls is a grave problem in sub-Saharan Africa. Greatly increased rates of HIV infection among young women and adolescent girls do not hold true globally, however, as is the case for the other three key populations listed in the paragraph (see (UNAIDS 2016c, 8-9). In PD2016, there are 64 references to women, and over thirty paragraphs focusing on their needs. PD2016, 42 is one of only two paragraphs in which key populations are named and there is no further articulation of their specific needs or commitments to meet them in this PD, despite these alarming infection rates.

This disparity, I suggest, is linked to the influence on PD2016 of the traditional religio-cultural discourse. Religious groups and MS supportive of a traditional religio-cultural discourse have systematically resisted the specific naming of key populations in UN negotiations, and have resisted attempts to discuss and articulate clearly the factors that put them at risk and to commit to strategies to address them. The MS interventions cited in chapter 9 are evidence of this. Women and girls are high priority groups for the traditional religio-cultural discourse because of the importance of the family and child-bearing to this discourse.

A clear example of the link between national sovereignty, a traditional religio-cultural discourse and absence of specific attention to key populations took place in 2013 when the Executive Board of WHO had a proposed agenda item on the health of homosexual persons (Daulaire 2013). Before adopting the agenda

for the meeting there were six hours of debate among Member States. Those supportive of a traditional religio-cultural discourse demanded that the item be removed, some stating that it was against the culture, religion and traditions in their country. States supportive of a rights and evidence-based approach to health wanted the agenda item to remain on the agenda as a valid topic for discussion. The meeting was only able to proceed when the agenda item was removed to a footnote, until further discussions were held with MS. It has never returned to the formal agenda of the Executive Board or World Health Assembly. The inability of the WHA to discuss the detailed health needs of homosexual persons and agree upon decision points to address those needs contributes to the gap in analysis and commitments in PD2016, since there is a gap in MS commitment on the issue at a technical level.

None of the PDs contain a clear articulation of the issues which put key population groups at risk of HIV, the concrete commitments and actions needed to address the epidemic among key population groups, or how to engage key population groups in scaling up effective community-based responses. References to these important issues all remain generic in nature. The strongest reference is in PD2016, 43 on drug use (General Assembly Resolution 2016, 43). This one paragraph does not match the level of detail afforded to women and girls in over thirty paragraphs of PD2016. Despite the level of detail in these paragraphs on women and girls, the PDs are silent on specific risks faced by sex workers.

8.5.2 References to the substantive and positive contributions of faith communities on HIV and AIDS

There is a broader religious discourse on AIDS which is supportive of human rights, gender equality and evidence-based approaches to HIV. As chapter 7 has documented, religious leaders, FBOs and local faith communities have been actively involved in AIDS work for 30 years. None of this work however, is reflected or mentioned as relevant to the HIV response in the text of the PDs.

Strategy2016 does name the contributions of the faith community as important and relevant to the HIV response and suggests eight ways in which contributions from the faith community strengthen national HIV responses. None of these suggestions are included in the PDs.

Strategy2016 suggests building partnerships with faith-based organizations and other civil society partners to address the social determinants of health transform unequal gender norms, and forge partnerships to defend human rights. It highlights the importance of engaging FBOs to reduce stigma and discrimination, in particular making the link between stigma and discrimination and poor health outcomes (UNAIDS 2015c, 39, 63, 65, 101). Strategy2016 suggests expanding service delivery options, including to scale up innovative models of service delivery, in particular through the faith-based networks of health facilities, including their community-based structures, and to identify best practice models that can be replicated (UNAIDS 2015c, 78, 80).

Strategy2016 also recognizes the important role of religious leaders as opinion leaders within communities and suggests engaging with religious leaders, to promote social justice and to monitor and evaluate the national HIV response (UNAIDS 2015c, 64, 99).

These are all very specific areas for partnership with faith-based actors in order to achieve the goals and targets of Strategy2016. PD2016 does not make any specific reference to the engagement of religious leaders or FBOs in any of these areas of work. They are completely missing from the text, despite evidence that FBOs are the largest provider of HIV services outside of national governments (PEPFAR 2015, 5).

The Joint Programme, as well as national AIDS councils and bilateral donors such as the US President’s Emergency Plan for AIDS Relief (PEPFAR) and the Norwegian Agency for Development Cooperation (NORAD) have worked actively with a wide range of religious and faith-based actors who are supportive of the broader religious discourse on HIV for over thirty years. None of this positive work or engagement is reflected in any of the PDs.

Chapter 6 argues that the reason for the complete absence of any meaningful inclusion of the broader faith response to HIV in the PDs is the dominance of secularism among member states of the WEOG group. This group of MS will work with FBOs outside of the policy-making space, and indeed fund some of their work, but appear to make every effort to keep any references to faith and religion out of the political negotiations.

8.6 Conclusions

This chapter has demonstrated how each of the four discourses appear in all four PDs on HIV & AIDS.

As PDs on an epidemic the public health and biomedical discourse is the dominant discourse, closely followed by the human rights and gender equality discourse. This is reflective of the broad definition of public health employed in the HIV response, which is inclusive of rights and gender.

The discourses tend to work in pairs: the public health and biomedical discourse together with the human rights and gender equality discourse and the traditional religio-cultural discourse together with the national sovereignty discourse.

There is evidence of tension and conflict between the discourses in some paragraphs in the PDs.

A traditional religio-cultural discourse is present in the text of all four Political Declarations on HIV & AIDS. It manifests in four main ways:

- Religion as a constituency (e.g. the faith-based health service providers) or set of issues pertinent to the HIV response. In these instances, there is no ideological weight behind the reference to traditional, religious and cultural issues mentioned. These references are minimal.
- To influence the tone of some paragraphs and frame issues or groups in line with the traditional religio-cultural discourse: e.g. women, framed as

passive, as victims, without agency to exercise their rights, primarily as mothers, home makers and care givers, this is explored further in chapter 9).

- To limit or qualify biomedical and rights-based approaches to combination HIV prevention and SRHR.
- To exclude references to key populations most at risk of HIV; to exclude both the framing of the issues that put them at risk and specific commitments to action.

The impact of a traditional religio-cultural discourse put forward at the UN through its supporters is greater in what it has succeeded in excluding from text of the PDs on HIV, than in the religious content within the text itself. The broad, bridge-building discourse and any reference to the substantive role of faith-based organizations in the HIV response is also missing from the text, as a result of hard secularism.

Chapter 9. 'Vulnerable groups', women and girls, young people and key populations in the PDs

9.1 Introduction

This chapter will attempt to answer five questions:

- How does a traditional religio-cultural discourse influence text in the PDs on women and girls?
- How does a traditional religio-cultural discourse influence text in the PDs on young people?
- How does the influence of the traditional religio-cultural discourse change over time? And how does use of the term 'vulnerable groups' demonstrate this?
- What are some of the potential sources of conflict and tension between the discourses?

Chapter 8 has discussed general findings of a close textual analysis of the four political declarations on HIV & AIDS and examines how the traditional religio-cultural and national sovereignty discourses influence the PD texts. It demonstrates that all four discourses appear in the text of all four PDs and that there is tension and conflict between the discourses. The traditional religio-cultural discourse influences the framing of women and young people in line with a traditional construction of women and young people as passive, as victims, and as in need of support and protection. The traditional religio-cultural and national sovereignty discourses work together to limit paragraphs on human rights and HIV prevention, and to block text on key populations.

This chapter builds on the evidence and analysis presented in chapter 8. Three case studies are presented, which focus on i) women and girls (see annex 9.1), ii) young people (see annex 9.2), and iii) the use of the terms 'vulnerable groups' and vulnerability (see annex 9.3). Close textual analysis is combined with an exercise to compare and contrast selected paragraphs in the PDs that exemplify a traditional religio-cultural framing or a human rights and gender equality framing of the issue. The Verloo template helps draw out the meanings

and subtext in some selected paragraphs (see annex 9.4). Where appropriate, the discussion comments on disparities between the goals, targets and recommendations of Strategy2016 and the commitments in PD2016.

The analysis and examples attempt to show how three pairs of contrasting concepts co-exist and create interpretive tension within the PDs:

- Two contrasting framings of women and young people portray them as passive victims and as people with agency and rights.
- In relation to tackling stigma and discrimination, two contrasting approaches are employed, focusing on the individual and on society/structures. These reflect Parker and Aggleton's conceptual framework on stigma and discrimination.
- The term vulnerable is used in two distinct ways: to describe those in need of protection from harms, and as a 'catch-all' phrase for key populations in the term 'vulnerable groups'.

These framings are characteristic of two different discourses, the traditional religio-cultural discourse and the human rights and gender discourse.

9.2 Analysis of women and girls

How does a traditional religio-cultural discourse influence text in the PDs on women and girls? Women and girls carry special meaning for the traditional religio-cultural discourse, as mothers, bearers of children, bearers of culture and tradition, and carers of the family and the sick (see chapters 4 and 5). Women and girls are also particularly vulnerable to HIV infection and its impact, especially in sub-Saharan Africa (see chapter 4).

All four PDs express 'deep concern' that women and girls are particularly vulnerable to HIV infection, are most affected and/or most at risk. In PD2001 and PD2016 these issues give rise to 'grave concern' (General Assembly Resolution 2001, 4 ,14, 2006, 7, 2011, 21, 2016, 15 ,41). In PD2016 data is added

to indicate that HIV is the leading cause of death of women and girls globally (General Assembly Resolution 2016, 33) (See annex 9.1).

9.2.1 Women as passive victims versus women as citizens with agency

Women and girls are framed in two contradictory ways in the PDs. Firstly, as passive and compromised, unable to protect themselves, victims of violence, recipients of services, subject to sexual violence, rape, trafficking, and harmful traditional and cultural practices. Language is carried over from one PD to the next, sometimes with modifications, but the general tone continues. In this passive framing, the focus is on women as individuals, and on increasing women's capacity to protect themselves from HIV infection and violence. There is also a focus on promoting and protecting their rights and providing them with services. They remain passive in receipt of these, however (General Assembly Resolution 2001, 4, 59, 60, 2006, 30, 2011, 21, 53, 2016, 61c) (see annex 9.1).

The second framing of women is as citizens with rights and agency. This tone is first evident PD2011, 41 and 81, and occurs in multiple paragraphs in PD2016 (see below). The focus of responsibility is on member states (MS) to address the structural issues and factors which lead to vulnerability, rather than on building the capacity of women to act as individuals and protect themselves (see annex 9.1).

This thesis argues that these differences in framing are the result of the influence of different discourses on the paragraphs. The passive framing, where the focus is on the individual, aligns with the traditional religio-cultural discourse, which characteristically portrays women as the primary bearers of children, as responsible for raising, feeding and caring for the family, and as bearers of traditional family values, religion and culture (see Chapters 5 and 6). This portrayal, including its focus on individual vulnerability, is in line with early approaches to the HIV response, (as explained in the conceptual framework set out by Parker and Aggleton, discussed in Chapter 3), which frames stigma and discrimination as the problem of individuals living with HIV. Correspondingly, approaches to address stigma and discrimination are directed at enabling the

individual to cope, and at increasing tolerance and acceptance of PLHIV by others (Parker and Aggleton 2003).

The second type of framing of women as people with citizenship, rights and agency is influenced by the human rights and gender equality discourse and aligns with the shift in approach to the HIV epidemic described by Parker and Aggleton in the second half of their conceptual framework, in which stigma and discrimination are seen less as an individual problem and more as evidence of structural inequities and dominant power structures, which maintain social control and the status quo (Parker and Aggleton 2003, 13). The response proposed by Parker and Aggleton is to address the structural determinants that maintain the unequal power structures. Similarly, the focus of action in the stronger PD commitments on women and girls is to address the structural issues. These two framings of women - the passive victim and the active citizen - in tandem with the influence of the two sets of discourses - the traditional religio-cultural and the human rights and gender equality discourse - can be seen running through each of the themes outlined in the following section.

The template of sensitizing questions by Verloo et al is designed to examine the text of public policy documents to draw out the 'hidden significance' and the power dynamics inherent within the text (Verloo 2016, 27). The problem is analysed according to its causes, the bearer of the problem, who is responsible, who has voice and who does not, who is the actor or perpetrator and who is the victim, etc. Questions are also asked about whether the text supports gender norms or legitimizes violence. All paragraphs in PD2011 and PD2016 on women and girls were interrogated using these questions. The results are discussed in the sections which follow.

When PD2011, 21 and 53 are interrogated using the Verloo template questions (see annex 9.4 for full analysis), the problems emerge as follows: women and girls are more affected by HIV; bear a disproportionate share of the care-giving burden; lack the capacity to protect themselves from HIV infection; lack the ability to exercise their right to control in matters relating to sexual and reproductive health without coercion, discrimination and violence; are subject

to unequal legal, economic and social status, sexual violence and exploitation; and lack access to healthcare services, including information and education (General Assembly Resolution 2011, 21 ,53).

Reasons for these problems include: that women are compromised and unable to protect themselves; they are unable to decide freely and responsibly, free from coercion, discrimination and violence; and they do not have economic independence, legal equity and adequate access to information, education and healthcare services (General Assembly Resolution 2011, 21 ,53).

Traditional gender norms in terms of women's and girls' identity, characteristics, social position and expected behaviours are all affirmed through this framing and match those of the traditional religio-cultural discourse. These norms are legitimized rather than challenged through the framing. Women's care-giving role is not challenged; rather its disproportionate size is considered a source of 'deep concern'. Violence is not legitimized; rather it is viewed as something to be eliminated. The discussion of sexual violence does however legitimize the passive nature of women as victims of unequal social, legal and economic structures in society, of discrimination, of violence and exploitation. The argumentation style in these paragraphs is one of concern, but not of taking responsibility. Those with voice in the document are MS, who are the duty bearers, not the women themselves. Correspondingly, it is therefore the MS who should to take responsibility and action. Actions suggested are framed in terms of enabling women to protect themselves as opposed to addressing the factors which put them at risk.

When PD2011, 41 and 81 are interrogated through the same template, a different picture emerges. In PD2011, 41, the central concept is that sexual and reproductive health services are essential for the HIV response. The primary actor is the government who has the responsibility to provide public health services for women and children. Women and children are not framed as passive victims, but as the rightful beneficiaries of services, as citizens (General Assembly Resolution 2011, 41) (see annex 9.1).

Paragraph 81 presents a similar picture when the template is applied. The primary actor is the state, who has the voice in the document. MS in this paragraph commit to ensure that 'national responses to HIV and AIDS meet the specific needs of women and girls, including those living with and affected by HIV, across their lifespan'(General Assembly Resolution 2011, 81). In this paragraph violence is not legitimized, neither is a passive or traditional framing of women. Rather MS commit to eliminate discrimination, 'as well as all types of sexual exploitation of women, girls and boys, including for commercial reasons, and all forms of violence against women and girls, including harmful traditional and customary practices, abuse, rape and other forms of sexual violence, battering and trafficking in women and girls' (General Assembly Resolution 2011, 81). The commitment by MS is to address the national legal, policy and other frameworks, to act as the duty bearer (see annex 9.1).

The Verloo analysis of these two paragraphs shows it is the state, not the individual, which is the player with voice in this document. States are to address the structural drivers of vulnerability such as policy and laws. These paragraphs are characteristic of a human rights and gender equality discourse, and in line with the conceptual framework put forward by Parker and Aggleton that advocates a rights-based approach in which discrimination is seen as a breach of the state's obligation to protect the rights of citizens (Parker and Aggleton 2003, 21).

These two very different framings are both present within PD2011. There was evidence of significant tension in the negotiations between supporters of the traditional religio-cultural discourse and supporters of the human rights and gender equality discourse in PD2011 to the extent that one MS arranged a private briefing to try to understand the tension and identify ways to achieve greater consensus. Previous sections of this thesis have demonstrated tension between the discourses operating inside one paragraph. This example demonstrates two different discourses operating in quite distinct ways in different paragraphs within the same document.

9.2.2 Build women's capacity versus address structural drivers of vulnerability

Gender Equality and the Empowerment of Women is a strong theme running through all the PDs. The framing and commitments around gender equality and women's empowerment in PD2001, PD2006 and PD2011 focus on building the capacity of women to protect themselves from risk. PD2001, 60 and 61 make two commitments to promote gender equality and women's empowerment with a focus on increasing women's capacities to protect themselves from HIV infection and promoting and protecting women's rights. In PD2006, 30, MS pledge to eliminate gender inequalities along with gender-based abuse and violence, both with the purpose of increasing the capacity of women and adolescent girls to protect themselves from risk (General Assembly Resolution 2006, 30).

In PD2011, 53 Member States:

> Pledge to eliminate gender inequalities and gender-based abuse and violence, increase the capacity of women and adolescent girls to protect themselves from the risk of HIV infection, principally through the provision of healthcare and services, including, inter alia, sexual and reproductive health, as well as full access to comprehensive information and education, ensure that women can exercise their right to have control over, and decide freely and responsibly on, matters related to their sexuality in order to increase their ability to protect themselves from HIV infection, including their sexual and reproductive health, free of coercion, discrimination and violence (General Assembly Resolution 2011, 53)

These paragraphs do not articulate ways in which MS will address the structural, social and legal issues that put women at increased risk of HIV infection and increase its impact in their lives. Whilst the provision of healthcare services is critical to meet the SRH needs of women, it is not an effective strategy to build their capacity to reduce their own vulnerability to HIV infection. The causes of this vulnerability are deeply rooted in social structures and for many women in

patriarchal cultures, control over decisions about their own sexuality and reproductive health is out of their personal sphere of influence. This is reinforced by their economic dependence on men and other factors (see Chapter 4) (see annex 9.1).

9.2.3 Member States protect rights and provide services

There is a shift in tone in PD2016. Initially wording from PD2011 is repeated in PD2016, 41 and 61c and the text recognizes that there has been little progress in this area (General Assembly Resolution 2016, 41, 61c) (see annex 9.1)

Then there is a shift in framing in PD2016, 61a) with the request that promotion and protection of human rights be mainstreamed into poverty eradication policies and programmes; and in PD2016, 61b) with the recognition that lack of promotion and protection of human rights, including 'sexual and reproductive health and reproductive rights' aggravates the impact of the epidemic. This is the first mention of SRH and RR in a PD on HIV. PD2016, 61d) advances the discussion in a different way and commits to some more specific interventions: to invest in gender mainstreaming; women's leadership; and 'engaging men and boys, recognizing that gender equality and positive gender norms promote effective responses to HIV'. The more specific MS commitments (highlighted in bold font in the paragraphs PD2016 61d-k in annex 9.1) begin to address the social norms which reinforce women's dependence on men and are reflective of the core actions in UNAIDS 2016-2021 Strategy (UNAIDS 2015c, 63) (General Assembly Resolution 2016, 61a, 61b, 61d) (see annex 9.1).

Each of these is a commitment to an action by government to address one of the structural determinants of risk and vulnerability to HIV infection and its impact. This is in line with the human rights and gender discourse rather than the passive victim type of framing characteristic of the traditional religio-cultural discourse. This shift is also characteristic of the second phase of the HIV response documented in Parker and Aggleton's conceptual framework, in which there is a more intentional attempt on the part of the HIV response as a whole, and MS to address the social norms and structural factors that increase risk and

vulnerability. This is an example of MS attempting to change the status quo, which maintains vulnerability.

Gender-based and sexual violence are themes which demonstrate the greatest shift in tone and language over time. The issue is framed in PD2006, 7 as one of deep concern, which increases the vulnerability of women and girls to HIV infection. Commitments are made in PD2001, 61 to eliminate ‘violence against women and girls, including harmful traditional and customary practices, abuse, rape and other forms of sexual violence, battering and trafficking in women and girls’. Similar commitments are made in PD2006, 30 and 31, and PD2011, 53 (General Assembly Resolution 2001, 61, 2006, 7, 30, 31, 2011, 53) (annex 9.1).

The first shift of tone occurs in PD2011, 81 where MS commit to ‘ensure national responses meet the specific needs of women and girls...by strengthening legal, policy, administrative and other measures for the promotion and protection of women’s full enjoyment of all human rights’ (General Assembly Resolution 2011, 81) (annex 9.1)

In PD2016 there is initially much repetition of earlier language, but the strengthened tone is picked up again in later paragraphs in a completely new way (61h, 61i, 61j and 61k). In these paragraphs MS commit to specific measures to end violence and discrimination against women and girls, for example, to address social norms (General Assembly Resolution 2016, 61h). This is the first time that the MS in a PD on HIV & AIDS have committed to address social norms, which are deeply rooted in religion, culture and tradition. Harmful practices are also spelt out in more detail, including ‘child, early and forced marriage, forced pregnancy, forced sterilization, in particular of women living with HIV, forced and coerced abortion and female genital mutilation’. MS commit to implementing laws to criminalize violence against women and girls, both in public and private, something which MS have been reluctant to consider in the past, particularly as this touches on the possibility of rape within marriage (General Assembly Resolution 2016, 61h, 61i) (annex 9.1). These are also issues closely linked to religion, culture and tradition.

In PD2016, 61i, governments also commit to review legislation which considers criminalization of violence against women, and to pursue prosecution. PD2016, 61j mentions providing emergency contraception and safe abortion, where 'permitted by national law' and forensic examinations post-rape. PD2016, 61k, policies and norms to prevent and punish violence against women and girls are proposed (General Assembly Resolution 2016, 61i, 61j, 61k) (annex 9.1). These paragraphs are also in line with core actions on sexual and gender-based violence in Strategy2016 (UNAIDS 2015c, 63).

These examples all demonstrate a shift from the individual focus and passive framing of women and girls to a framing which identifies the state as the primary actor to address the social determinants of risk and vulnerability and meet their obligations to the rights of women and girls as citizens. The core actions on women and girls outlined in Strategy2016 are broadly included in PD2016, with the exception of SRHR, commitment to address the HIV-related needs of sex workers and action to address legal requirements for third person consent to access SRH services. Some of these concepts also pose a direct challenge to the traditional religio-cultural discourse, which has opposed them in the past.

9.3 Analysis of young people

How does a traditional religio-cultural discourse influence text in the PDs on young people? This section will demonstrate that young people in the early PDs are framed in passive terms, in the same way as women and girls, and that this is characteristic of the paternalistic tone of the traditional religio-cultural discourse. The focus of the earlier PDs is on equipping young people to protect themselves from HIV infection, but their rights to information and services are not mentioned until PD2016. Member States repeatedly express concern that young people are limited in their access to sexual and reproductive health, information and services, and that policies and legislation may limit their access, but do not take responsibility to shift those laws and policies until 2016. Even in PD2016 there is evidence of a reticence to use the term comprehensive sexuality

education and affirm the sexual and reproductive health and rights of young people (see annex 9.2 for original text to support discussions in this section).

In PD2001 the first reference to young people acknowledges their contribution to the epidemic and calls for their inclusion in multi-sectoral national strategies as members of 'vulnerable groups' and those most at risk. The main commitment on young people is framed entirely according to the traditional religio-cultural discourse and appears in paragraph 63. This paragraph, already discussed in chapter 8, does not address the sexual and reproductive health needs and rights of young people, rather it positions the family, not the state, as the central actor in guiding and educating them (General Assembly Resolution 2001, 33, 37, 63) (annex 9.2).

In PD2006 the first mention of young people is to express 'grave concern that half of all new HIV infections occur among children and young people under the age of 25', and that they lack 'information, skills and knowledge regarding HIV & AIDS' (General Assembly Resolution 2006, 8). Member States commit to address high HIV rates among young people in PD2006, 26. The commitment is predominantly biomedical in approach and provides a list of HIV prevention options, including condoms. It includes one term characteristic of the traditional religio-cultural discourse, namely to call for 'responsible sexual behaviour', but there is no mention of abstinence or fidelity. There are no references to young people's rights to information or services. Omission of any reference to the rights of young people is consistent with the paternalistic approach of the traditional religio-cultural discourse towards young people, which does not promote the agency, decision-making, or rights of women and young people on sexual health and sexuality issues (General Assembly Resolution 2006, 26) (annex 9.2).

PD2011, 25 expresses 'grave concern' that HIV infection rates among young people 'account for more than one third of all new HIV infections, with some 3,000 young people becoming infected with HIV each day'. Passive language again is used in framing young people's needs, which is characteristic of the traditional religio-cultural discourse. They are described as having limited access

to SRH services, education and information; ‘only 34 per cent of young people possess accurate knowledge of HIV’. The paragraph ends with a prescriptive sentence strongly reflective of the traditional religio-cultural discourse: ‘recognizing the importance of reducing risk taking behaviour, encouraging responsible sexual behaviour, including abstinence, fidelity and the correct and consistent use of condoms’. This paragraph mentions that ‘laws and policies in some instances exclude young people from access to services’, but MS do not take responsibility in their commitments to address those restrictive laws. This limits the rights and agency of young people to take control of their own HIV prevention needs (General Assembly Resolution 2011, 25). (see annex 9.2).

Correspondingly, the commitments in PD2011 are particularly weak and vague with respect to young people: in PD2011, 56 Member States commit to ‘encouraging and supporting the leadership of young people, including those living with HIV’, but provides no substantive content on what the young people will be engaged to do. The paragraph indicates that the youth will develop ‘specific measures’ (undefined) to engage other ‘young people in HIV’ (on what and how is also not defined) in a range of different settings (General Assembly Resolution 2011, 56) Mindful of the questions posed in the Verloo analysis, in the context of a political negotiation on HIV, Member States are the duty bearers. They have voice in the document and make commitments on behalf of their citizens in a health crisis. In these examples however, the problems are clearly identified, but Member States do not propose any actions to address restrictive laws, or engage young people in project planning, implementation and evaluation (see annex 9.2).

By contrast, PD2011, 57 on the engagement of people living with HIV is clear and specific. It states that people living with HIV will be engaged ‘in decision making and planning, implementing and evaluating the response’. It also commits ‘to develop and scale up community-led HIV services’. This demonstrates that specific thinking about engagement of different groups in programmatic areas of the HIV response was present in the negotiating space at the time. I would argue that the vague and unspecified nature of MS commitments in PD2011, 56 and 59 also lies in the reticence of supporters of the traditional religio-cultural

discourse to assign leadership, rights and agency to both women and young people.

PD2011, 59b), which returns to the theme of ‘harnessing the energy of young people’ in leadership, fails to provide substantive content on what form this leadership should take. PD2011, 59c) repeats for the third time in this declaration language on abstinence and fidelity from PD2001, applying it in this instance to young people: ‘Reducing risk-taking behaviour and encouraging responsible sexual behaviour including abstinence, fidelity and consistent and correct use of condoms’ (General Assembly Resolution 2011, 59b-c). PD2011, 59e) adds the detail of ensuring that young people ‘have the means to exploit the potential of new modes of connection and communication’ but does not specify how this potential can be used for HIV prevention, or how Member States will make new modes of communication available (see annex 9.2).

Chapter 8 and section 9.2 demonstrate how PD2011 consistently uses language and framing characteristic of a traditional religio-cultural discourse to limit and restrict comprehensive approaches to HIV prevention, education, sexual and reproductive health services and rights for women. These paragraphs demonstrate similar limitations applied to young people (General Assembly Resolution 2011, 25, 56, 59b, c, e).

9.3.1 Comparing the framing of young people’s HIV-related needs in PD2011 vs PD2016

There is evidence of a change of tone in PD2016, 39 however, which frames the HIV-related issues facing young people. It highlights that young people account for more than one third of new infections, and AIDS is the second largest cause of death among adolescents globally. This paragraph is stronger than the corresponding framing paragraph on young people in PD2011, 25 in a number of specific ways. For instance, additional data on deaths is added to support the case in PD2016: AIDS is ‘the second leading cause of death in adolescents globally’ (General Assembly Resolution 2016, 39) (see annex 9.2).

PD2011, 25 comments on limited access to 'sexual and reproductive health programmes that provide the information, skills, services and commodities they need to protect themselves' (General Assembly Resolution 2011, 25). In PD2016, 39 the gaps are identified more specifically with reference to limited 'sexual and reproductive health-care services and programmes that provide the commodities, skills, knowledge and capability they need to protect themselves from HIV' (General Assembly Resolution 2016, 39). The focus is still on the young people protecting themselves from HIV, however. In this paragraph the state does not take responsibility to address the factors which affect vulnerability of young people to HIV.

In PD2016, data on knowledge of HIV prevention methods is disaggregated by sex, which was not the case in PD2011. In PD2011, 25 young people are reported to be excluded from 'accessing sexual health-care and HIV-related services, such as voluntary and confidential HIV-testing, counselling and age-appropriate sex and HIV prevention education, while also recognizing the importance of reducing risk taking behaviour and encouraging responsible sexual behaviour, including abstinence, fidelity and correct and consistent use of condoms' (General Assembly Resolution 2011, 25).

In PD2016, 39 the level of detail is greater, in that young people are excluded from 'accessing sexual and reproductive health-care and HIV-related services, such as voluntary and confidential HIV testing, counselling, information and education, while also recognizing the importance of reducing risk-taking behaviour and encouraging responsible sexual behaviour, including correct and consistent use of condoms'. Reproductive healthcare is added, the reference to information and education is not qualified by 'age-appropriate', which acts to limit the provision of full information, and finally the references to abstinence and fidelity are removed (General Assembly Resolution 2016, 39). Comparison of these two paragraphs demonstrates how PD2016 is stronger and clearer than PD2011 and includes fewer limiting statements or attempts by the traditional and national sovereignty lobby to restrict a paragraph than in 2011 (see annex 9.2).

9.3.2 Greater strength of commitments on young people in 2016

This final section of the analysis on young people will show how the strength of commitments on young people in PD2016 are stronger than those in PD2011. PD2016, 47 highlights the needs of young people and, for the first time, includes the rights of young people to sexual and reproductive health and HIV services, and legal services for those who have experienced gender-based violence. PD2016, 62d) commits 'to saturate areas with high HIV incidence with a combination of tailored prevention interventions…with particular focus on young people, particularly young women and girls'. PD2016, 62j) commits 'to eliminate barriers, including stigma and discrimination in health-care settings, to ensure universal access to comprehensive HIV diagnostic, prevention, treatment, care and support for people living with, at risk of, and affected by HIV, persons deprived of their liberty, indigenous people, children, adolescents, young people, women, and other vulnerable populations'. PD2016, 63f) commits 'to promoting laws and policies that ensure the enjoyment of all human rights and fundamental freedoms for children, adolescents and young people'. PD2016, 64a) calls 'for increased and sustained investment in the advocacy and leadership role, involvement and empowerment of people living with, at risk of, and affected by HIV, women and children, bearing in mind roles and responsibilities of parents, young people, especially young women and girls'. Finally PD2016, 64b) commits 'to encouraging and supporting the active involvement and leadership of young people, particularly women, including those living with HIV, in the fight against the epidemic at the local, sub-regional, regional, national and global levels' (General Assembly Resolution 2016, 47, 62d, 62j, 63j, 64a, 64b) (see annex 9.2).

All of these commitments except 64b are stronger than those made by MS in PD2011 (64b does not provide any more specific information on how this leadership will be exercised than PD2011). Some of these also demonstrate commitments of responsibility by the MS as the duty bearer to address the structural determinants of HIV vulnerability experienced by young people, such as legislation that restricts their access to information and services to prevent HIV infection, stigma in healthcare settings, and promoting and protecting the

human rights and fundamental freedoms of young people. Commitments in PD2016 broadly match the core actions of UNAIDS strategy on young people, reflect the human rights and gender equality discourse, and the structural approach to HIV stigma and discrimination discussed in the conceptual framework of Parker and Aggleton (UNAIDS 2015c, 10).

9.4 Analysis of the use of the term 'vulnerable'

This section addresses the questions: how does the influence of the traditional religio-cultural discourse change over time? And, how does use of the term 'vulnerable groups' demonstrate this?

An example of tension between the discourses in the PDs is the use of the term 'vulnerable'. In UNAIDS strategies, the public health, biomedical and human rights, gender equality discourses clearly name the key populations that the epidemiological evidence demonstrates are at increased risk of HIV infection. This thesis argues that the use of the term 'vulnerable groups' as a 'catch-all' phrase for key populations is characteristic of the traditional religio-cultural discourse and the national sovereignty discourse. This is evidenced by the MS interventions resisting the specific naming of key population groups in negotiations at the UN and the WHA. In addition, the traditional religio-cultural discourse frames women, young people, children and other people in need as vulnerable and therefore in need of help or rescue in its literature and practical approaches to HIV. The theological concepts of sin and salvation are often reflected in these understandings of vulnerability.

9.4.1 Sin, salvation and vulnerability

When sexual relationships, and acts which fall outside religiously accepted moral boundaries are framed as sinful, then individuals are often stigmatized, rejected and marginalized by their families, faith communities and society. Similarly, when HIV infection is framed as a punishment for individual sexual sin, then people living with HIV are also rejected and marginalised. In both instances this increases individual vulnerability to HIV infection and its impacts.

Early literature on AIDS from Christian and other faith traditions often framed HIV infection as a punishment from God, because of individual sinful (sexual) behaviour. Traditionally, when religion sets the moral structures and boundaries for community, and this becomes the 'official code' for society then people who step outside of these boundaries are a challenge to the status quo, and society's response is often to punish, stigmatize or scapegoat the individuals, or to attempt to 'save' them from their 'sin' or 'rescue' them in order to restore moral and social order (Parker and Aggleton 2003) (Paterson 2009). Practical consequences of religion setting the moral code for society based on individual framing of sin and salvation, also include religiously justified 'raid and rescue' approaches to sex work and trafficking. These attempts to 'rescue' individual women and children from situations considered to be immoral or unsafe and 'save' the victims through 'rehabilitation' of women, or by placing children in orphanages.[34]

Both the Old and New Testament Scriptures challenge the assumption that personal sins are the cause of suffering and sickness. In the Old Testament this is seen in the book of Job and in the Psalms. In the Gospels, Jesus repeatedly challenges the religious leaders, who laid a heavy moral burden on the people, yet did not always live up to their own strict demands. He presents the kingdom of God as pro-poor, for the marginalized and the outcast, and inclusive of women. His crucifixion outside the city walls was itself a powerful statement that no-one is beyond salvation; he died for the 'other' (McDonagh 1994) (Paterson 2009) (Clifford 2004).

The scale of theological reflection on AIDS reflects the magnitude of the suffering. Catholic theologian Enda McDonagh points out that:

> Liberation theologies of the Latin American, black and feminist kinds are only the most recent examples of how serious social challenges with their

[34] I discuss this at some length in *Part of the solution and part of the problem?* (Smith 2016). These issues are highly complex, and while under age sex workers, and those engaged in sex work against their will may need support to find a place of safety, this is different to ideologically driven 'raid and rescue' approaches. In practice, a combination of support to the individual as well as action to address the structural injustices and inequities which put them at risk may well be needed.

> new questions on human meanings and morals have compelled serious and fruitful rereading of these scriptures and traditions. It would be rash to claim at this stage at any rate that AIDS/HIV could have far-reaching implications for the practice of theology and the understanding of Christian faith. The experience of liberation theologies should, however, alert us to underestimating the impact of the pandemic on Christian thinking and practice and above all preclude reducing the discussion to marginal if genuinely important details like the use of condoms or exchange of needles in programmes of prevention. The questions for theology raised by AIDS/HIV may not be confined within the conventional limits of moral theology. (McDonagh 1994, 3).

HIV has challenged Catholic moral theology (and indeed other Christian theological traditions), with its focus on natural law to revisit the link between personal sin and suffering. Whilst natural law has provided an important biblical basis for HIV responses it is ‘a first step, if only a first, in seeking some mutual moral understanding on AIDS/HIV with people of quite different religious and cultural backgrounds. For Catholics and people sharing a similar philosophical background it will continue to sustain and illuminate moral analysis’ (McDonagh 1994, 6). Other authors, including Gillian Paterson, call for Christian scholars of ethics and moral theology to move beyond early understandings of sin surrounding sex and sexuality, which increase stigma and discrimination (Paterson 2009).

Consider the vulnerability of young women; in many cultures they cannot decide with whom, when and where to have sex, whether to marry and how many children to have, nor can they control their partners’ fidelity or ask them to use condoms to protect against HIV infection or pregnancy. Chapter 3 has documented the factors which increase the vulnerability of young women to HIV infection, many of which are outside of their individual control. Those living with HIV, and rejected by family and community, are subject to further vulnerabilities if they have no home or income. Paterson considers the Biblical story of the woman caught in adultery and asks was she ‘the victim’, ‘the sinner’, or ‘the scapegoat’ for the sins of others? This challenges faith

communities to think more deeply about the linkages between theologies of sin and the consequences of stigma and vulnerability (Paterson 2009, 5).

Christian theological reflections on HIV shifted over time from the focus on individual sin to theological exploration of social justice, and structural sins. Paterson highlights that those most vulnerable to HIV, such as sex workers, men who have sex with men, and people who use drugs are those who are most marginalized by religious communities. She challenges churches to mount holistic responses to HIV, that address invisibility, silence, and criminalization of vulnerability (Paterson 2009, 11).

A focus on individual sins leads to ‘othering’ and marginalization of those individuals who are different to socially accepted norms. Theological approaches that challenge the very social norms that result in this ‘othering’, exclusion and marginalization are a feature of later theological reflections on HIV. This shift from a focus on the individual to a focus on structural injustice is an approach that is in line with the second phase of Parker and Aggleton’s conceptual framework described earlier in this chapter. They provide a theoretical framework for the major shift in the conceptualization of stigma from a focus on the individual to a much stronger approach, which addresses the structural inequalities underlying vulnerability to HIV. (Parker and Aggleton 2003). Margaret Farley, Robert Kaggwa (in his response to Margaret’s paper) and Paula Clifford, each in different ways talk of sin in structural terms: how poverty is linked to increased vulnerability to and impact of HIV infection through a complex intersection of colonialism, inequitable trade relationships and gender inequity (Farley 2009) (Clifford 2004).

When people are deprived of access to HIV prevention, treatment, care and support services because they are members of a marginalized key population, their vulnerability to HIV infection and its impact on their lives is increased. Kelly and others have argued that ‘AIDS exacerbates inequity and injustice: in turn, inequity and injustice increase vulnerability to HIV infection. One cannot be understood without understanding the other’ (Kelly. 2010: 17). To illustrate this point, a widow whose husband has died of AIDS, in a country where women are minors in the eyes of the law, cannot inherit the family home. As her property and land are taken from her, she may resort to sex work to support her

children. The subsequent advent of AIDS into her life and family as a result of her engaging in sex work, exacerbate the gender inequity and social injustice of inheritance law, which increased her vulnerability to HIV infection (Smith 2013) (Smith 2016, 16). Rather than condemning her for individual 'sin' sex worker activists advocate a structural approach to problems such as this. They 'reject both the ideology of 'rescuing' women from prostitution and the human rights violations associated with coercive or moralistic programmes. They argue that money would be better spent on increasing sex workers' access to justice, education, safe workplaces, finance, housing, health care and other building blocks of fulfilled lives' (Overs 2014).

9.4.2 How use of the term 'vulnerable' changes over the four PDs

This section will track use of the word vulnerable through all four PDs as a case study. It discusses how the term is used, and how it changes over time as an example of how the traditional religio-cultural and national sovereignty discourses influence the text (readers are referred to annex 9.3 for original text to support discussions in this section).

9.4.2.1 Use of the term 'vulnerable' in PD2001

PD2001 contains 27 references to vulnerable or vulnerability, which occur in 19 paragraphs. Three of its sub-headings include the word vulnerable. This constitutes the strongest framing of the concept across all the PDs. In PD2001, 19, 27, 32, 37 and 46, people at risk of HIV are referred to through the catch-all phrase 'vulnerable groups'. This strategy avoids naming key populations. The term 'key populations' is absent from PD2001 or PD2006 (General Assembly Resolution 2001, 19, 27, 32, 37, 46).

The UNAIDS Global Strategy Framework on HIV/AIDS, 2001 provides a series of clear outcomes to address risk, vulnerability and impact of the HIV epidemic, which are expressed in neutral ways. It states: 'Ways of reducing the risk of HIV infection: postponing first sexual intercourse; safer sexual practices such as consistent condom use; reducing the number of sexual partners;' (UNAIDS 2001, 9). In PD2001, 62 however, that level of clarity is absent. Instead, as examples

of 'activities which place individuals at risk of HIV infection', it lists 'risky and unsafe sexual behaviour and injecting drug use'. PD2001 uses a value judgement and avoids naming specific behaviours which can be addressed by specific actions. This is characteristic of the traditional religio-cultural discourse (General Assembly Resolution 2001, 62) (see annex 9.3).

In PD2001, 48, however, the use of the term vulnerability is different. In this paragraph, the call is to recognize and address factors which increase people's vulnerability to HIV. These factors are themselves highly complex and include social, cultural, religious, biomedical and anatomical factors, as well as legal and economic factors such as poverty and legislation to criminalize certain behaviours. PD2001 does not draw out the nuances of these factors well, but at this point does recognize the difference between 'vulnerable groups' and factors which make people vulnerable (see annex 9.3).

PD2001 takes the discussion of vulnerability further under a series of sub-headings, which include the term vulnerable. Under the first heading: 'HIV/AIDS and human rights: *Realization of human rights and fundamental freedoms for all is essential to reduce vulnerability to HIV/AIDS'*, PD2001, 58 recognizes the need for robust legislation to ensure that the human rights and fundamental freedoms of people living with HIV and 'vulnerable groups' are protected, specifically with regard to access to services. In this section, PD2001, 61 makes the same link between the need to promote and protect women's human rights to reduce their vulnerability to HIV & AIDS. In both paragraphs the link between protecting rights and reducing vulnerability is recognized in line with the UNAIDS Strategy (General Assembly Resolution 2001, 58, 61) (UNAIDS 2001) (annex 9.3).

Under the heading, 'Reducing vulnerability', there are two sub-headings: '*The vulnerable must be given priority in the response*'; and '*Empowering women is essential for reducing vulnerability*'. There is a discrepancy here between the outcomes to reduce vulnerability in the UNAIDS Strategy and PD2001. The Strategy calls, among other very specific things, for a reduction of stigma associated with sex, sexuality, sex work and drug use (UNAIDS 2001, 10). PD2001, 62 highlights factors that make people vulnerable, including: 'all types

of sexual exploitation of women, girls and boys, including for commercial reasons'. However, it fails to name sex work or address the stigma associated with sex work, sexuality or drug use (General Assembly Resolution 2001, 62) (see annex 9.3).

PD2001, 62 does recognize the need to address 'factors that make individuals particularly vulnerable to HIV infection, including underdevelopment, economic insecurity, poverty, lack of empowerment of women, lack of education, social exclusion, illiteracy, discrimination, lack of information and/or commodities for self-protection'. The call in this paragraph is to develop policies to address these vulnerabilities. PD2001 does not go as far as describing and addressing these factors as structural determinants of vulnerability however, but does make the link between the lack of these things and vulnerability to HIV (General Assembly Resolution 2001, 62).

PD2001, 63 focuses on strengthening the family as a key factor in reducing vulnerability, which, as already discussed, is central to the traditional religio-cultural discourse. PD2001, 64, focuses on strategies to promote and protect the health of the individuals in a group. This is the first mention of 'identifiable groups'(General Assembly Resolution 2001, 64). In a third section, dedicated to addressing the needs of orphans and vulnerable children, there is no tension between the discourses.

9.4.2.2 Use of the term 'vulnerable' in PD2006

In PD2006, the use of the term vulnerable is reduced to 11 mentions: two refer to orphans and vulnerable children, 4 to increasing or addressing vulnerabilities and the 5 use the term 'vulnerable groups' as a catch-all phrase. There is no advance in the discussion of factors that make people vulnerable to HIV infection.

9.4.2.3 Use of the term 'vulnerable' in PD2011

In PD2011, 4, the first mention of vulnerabilities uses the term in a different way. This paragraph talks about the distinctive national 'drivers, vulnerabilities, aggravating factors and the populations that are affected', and calls for national responses to be 'uniquely tailored' to the social context. In this paragraph, the term is used in line with the national sovereignty discourse. PD2011 still uses the term vulnerability to avoid naming key populations, who the evidence shows to be at increased risk of HIV infection in all countries; but it does not use the 'catch all' approach of 'vulnerable groups', rather it uses a different strategy and focuses on the difference between national epidemics (General Assembly Resolution 2011, 4) (see annex 9.3).

PD2011, 43 presents the family as central to reducing the vulnerability of children and young people, as per the traditional religio-cultural discourse (General Assembly Resolution 2011, 43).

In PD2011, 27 the term 'populations vulnerable to HIV infection' is introduced. The term population increases in usage from one reference in PD2006 (unrelated to vulnerability) to 11 references in PD2011, all of which refer to populations who are vulnerable, at higher or increased risk of HIV infection. This demonstrates a marked increase in the nuance and differentiation of the framing of risk and vulnerability in PD2011 from PD2001 and PD2006. The use of the term vulnerable also changes in some paragraphs; it shifts from the passive 'made vulnerable' to the more neutral 'vulnerable to'. PD2011 includes new commitments and strategies to address vulnerability: to strengthen social protection systems PD2011, 82; and to address the vulnerabilities to HIV of mobile and migrant populations in line with national legislation PD2011, 84 (General Assembly Resolution 2011, 82, 84) (see annex 9.3).

Over time, the use of the term 'vulnerable groups', as a catch-all phrase decreases, and the term 'populations at higher risk of HIV infection' is gradually introduced. Annex 2.2 shows this trend.

9.4.2.4 Use of the term 'vulnerable' in PD2016

By PD2016, there is evidence of a further shift in the use of the terms vulnerable and populations, reversing their frequency, such that there are 27 references to population and 12 to vulnerable. PD2016 shows a much greater differentiation in the use of these terms and the catch-all phrase 'vulnerable groups' is missing. PD2016, 14 refers to 'universal health coverage and social protection of people in *vulnerable situations*'. PD2016, 15 notes the 'particular vulnerability of women and girls'. PD2016, 45 highlights the 'increased vulnerability to HIV infection of women and girls with disabilities'. PD2016, 49 and 59g refer to challenges facing the 'most vulnerable countries'. PD2016, 57 highlights again the need for differentiated national responses based on 'local priorities, drivers, vulnerabilities, aggravating factors, the populations that are affected and strategic information and evidence'. PD2016, 60h commits to providing access to medicines for 'vulnerable populations and populations that epidemiological evidence shows are at higher risk of infection'. PD2016, 60n refers to the 'heightened HIV vulnerability, risk of treatment interruption' in situations of conflict. PD2016, 61b refers to the lack of protection and promotion of women's human rights, and lack of access to the highest possible standard of healthcare with regard to SRHR, which increase the vulnerability of women and girls to HIV infection and its impact. PD2016, 61h makes a commitment to end violence against women and girls, recognizing its link to HIV vulnerability (General Assembly Resolution 2016, 14,15, 45, 49, 59g, 57, 60h, 60n, 61b, 61h) (see annex 9.3).

The above analysis has documented how the term vulnerable is used and how the usage changes. Over time its use has become more focused on the factors which increase vulnerability to HIV, which is a more appropriate use of the term, than its use as a 'catch-all' phrase for key populations. In PD2016 its use is more nuanced than in the earlier PDs, reflecting a range of different vulnerabilities and strategies to address them. Some of these are structural determinants of vulnerability. The use of the term 'vulnerable groups' as a catch all for key populations has been replaced by a range of terms such as 'populations at higher risk of HIV' infection, thus releasing the term vulnerable to be used more accurately.

9.5 Resistance by Member States

This section demonstrates how these changes and the associated introduction of references to key populations is resisted by MS based on a traditional religio-cultural discourse. In 2011 there was significant resistance to the wording of paragraph 29, which names three key populations at higher risk of HIV infection for the first time in a PD, (sex workers, men who have sex with men, and people who inject drugs). This is the only naming of key populations in PD2011, prisoners are mentioned once and the transgender community are not mentioned at all (General Assembly Resolution 2011). Even though in PD2011, 29 key populations are named and the term 'populations at higher risk of HIV infection' is introduced in PD2011, 27, there is ongoing pressure from some MS to use the term 'vulnerable groups'. This is evidenced by an increase from 3 to 11 references to vulnerable between the zero draft and the final text of PD2011 (United Nations 2011a).

The Zero draft of PD2011, 29 (originally numbered 16) states:

> 16. Note with concern that many national prevention strategies ignore or inadequately focus on three populations that are at higher risk of HIV infection, specifically men who have sex with men, people who inject drugs and sex workers and their clients and, accordingly, that many people from these populations find it difficult or impossible to access HIV services (zero draft 2011);

The final draft states:

> 29. Note that many national HIV prevention strategies inadequately focus on populations that **epidemiological evidence shows are at higher risk**, specifically men who have sex with men, people who inject drugs and sex workers, and further note, however, that **each country should define the specific populations that are key to its epidemic and response, based on the epidemiological and national context** (General Assembly Resolution, 2011, 29).

The phrases in bold were added during the negotiation process. The following statements made by MS at the adoption of PD2011 confirm this and demonstrate some of the tensions in negotiations that have contributed to the final text:

> An observer for the Holy See, however, rejected the text's references to so-called "harm reduction", and efforts related to drug abuse, saying that those terms falsely suggested that those suffering from HIV/AIDS could not break free from the cycle of addiction. Governments and society must not accept such a dehumanization and objectification of persons. What was needed was a value-based approach to counter the disease of HIV and AIDS, which provided the necessary care and moral support for those infected and promoted living in conformity with the norms of the natural moral order, respecting fully the inherent dignity of the human person.
>
> Syria's representative, speaking on behalf of the Arab Group, voiced his "complete rejection" of the inclusion of certain groups among the list of populations considered to be the most vulnerable, saying that all groups should be treated equally and that none should be put above others.
>
> Similarly, Iran's representative said the "overly targeted" document particularly paragraph 29, which noted that many national HIV prevention strategies inadequately focused on higher risk populations, including men having sex with other men, drug users and sex workers — failed to recognize the detrimental role of risky and unethical behaviours in the spreading of the disease.
>
> Brazil's representative described the inclusion of references to those groups as "far-reaching achievements", lauding such groups for their important role in developing policies to fight the epidemic. In addition, it was important that, for the first time, targets had been set on reducing mother-to-child transmission and achieving access to antiretroviral drugs (United Nations 2011b).

There are some interesting additional observations from this case study. Firstly, there is a clear link between the traditional religio-cultural discourse and the national sovereignty discourse, which is not evident in the wording of PD2011, 29, but comes out in the interventions of Iran and the Holy See following its adoption.

The wording of paragraph 29 does not include any traditional religio-cultural references but does include a call from the perspective of a national sovereignty discourse for nations to define the key populations relevant to their own context. This limits the original intention of the paragraph, which sought to focus more on named key populations.

MS comments, following adoption of the text, include two examples of traditional religio-cultural discourse language. Iran refers to 'unethical behaviours', and the Holy See refers to 'the norms of the natural order'. This sequence is a good example of the complex and supportive inter-relationship between the two discourses and the success of this approach in removing additional references to the needs of key populations from the text.

The main themes listed above emerge in all four PDs from 2001 to 2016. There is evidence of a change over time, with a much greater nuance of analysis and strength of both framing and commitments evident in 2016 in comparison to the other PDs.

9.6 Discussion on sources of conflict

This section addresses the question: what are some of the potential sources of conflict and tension between the discourses?

9.6.1 Identifying conflicts between the conceptual frameworks

As outlined in chapter 2, one of the steps in interdisciplinary research is an interrogation of the conceptual frameworks, which underpin the discourses and a mapping of the assumptions, concepts and definitions on which they are built.

Conflict between the underlying assumptions and definitions within the conceptual frameworks is often the source of conflict between disciplines, and hence the discourses. This insight enables the researcher to pinpoint some of the underlying reasons for the tension and conflict between the discourses. With this insight potential areas of synergy or common ground can be identified that are based on an understanding of the underlying synergies between the conceptual frameworks. Failure to complete this step, risks the researcher proposing potential areas of common ground, which are incompatible due to an underlying conceptual conflict (Repko 2008, 217, 248).

The conceptual frameworks, which underpin the four discourses operational at the UN are: the Sustainable Development Goals (SDGs); the Gender mainstreaming conceptual framework for the Council of Europe (Council of Europe 1998) (the CEGM framework); the HIV and AIDS-related stigma and discrimination conceptual framework and implications for action (Parker and Aggleton 2003) (the SDHIV framework); and the Natural Law theory as framed by the Catholic Church (Catholic Church 1997a, b) (the NLCC framework). Chapter Five discussed natural law theory, highlighting the extensive and diverse nature of Christian theological reflection and teaching on this theme. In the negotiations at the UN however, the full breadth of this teaching and theological reflection is not reflected. Rather, a more limited framing of natural law theory is put forward by the Holy See, in support of Catholic teaching on sexuality and family. It is this conservative presentation of natural law which will be discussed in this chapter.

From the mapping of assumptions, definitions and concepts it is immediately clear that there are several areas of conflict between the conceptual frameworks and some areas of potential common ground. These are discussed in the sections which follow.

9.6.2 Identifying areas of potential conflict between the disciplines

The mapping provides a simple way to compare the main assumptions, definitions and concepts of the three theoretical frameworks. There are clear

differences between the conceptual frameworks in the areas of gender equality, sexuality and agency (see annex 1). These fall into three groups.

9.6.2.1 Group 1: Conflicts around gender equality

There are areas of potential conflict between the CEGM framework and the 'natural law theory' (NLCC). The CEGM definition of gender equality includes the right to be different in relation to sexual orientation (Council of Europe 1998, 8). This conflicts with the Catechism's teaching that homosexual inclinations are 'objectively disordered' (Catholic Church 1997b, 2358). CEGM's promotion of free choice in matters of reproduction and lifestyles (Council of Europe 1998, 9) conflicts with the duty of married couples to have children (Catholic Church 1997b, 2363).

These conflicts arise when the rights or choices promoted by the CEGM and SDHIV frameworks (which underpin a public health, human rights and gender equality discourse) extend beyond the definitions of sexuality and marriage prescribed by the NLCC (which underpin the traditional religio-cultural discourse). An additional element in this conflict is that the definitions of sexuality in the NLCC framework are considered by traditional religio-cultural discourse supporters as, not only ordained by God, but also inscribed in human hearts beyond those adherents to the faith, such that they are prescriptive for all.

9.6.2.2 Group 2: Conflicts around the definition of normality

This second group of conflicts concern definitions of normality and deviance and the way these definitions are used either by the NLCC framework to maintain power and social control, or by the CEFM and SDHIV frameworks to shift existing power structures and extend the definitions of normal to include those previously excluded.

On sexuality, the Catechism teaches that prostitution is a 'social scourge' and 'always gravely sinful'(Catholic Church 1997a, 2355); homosexual tendencies are

'objectively disordered' (Catholic Church 1997a, 2358); homosexual persons are called to chastity (Catholic Church 1997a, 2359); and 'The conjugal love of man and woman thus stands under the twofold obligation of fidelity and fecundity' (Catholic Church 1997a, 2363).

These excerpts contain clear statements, which conflict with the SDHIV framework. The Catechism indicates that the *natural law* is 'immutable' and 'permanent', applies to all, and that this law determines the basis for people's human rights (Catholic Church 1997b, 1956). When combined with the NLCC definitions of 'deviance', 'disorder' or sin in the teaching on sexuality, this set of quotations provides a clear example of what the SDHIV would describe as 'rules' based on 'coercion' and creating a 'hegemony' through social structures to legitimize the domination of a traditional religio-cultural discourse and concretize the marginalization of key populations most at risk of and vulnerable to HIV (Parker and Aggleton 2003, 18).

In addition the statement that *'natural law… 'expresses the dignity of the person and determines the basis for his fundamental rights and duties'* (Catholic Church 1997b, 1956) takes the link between human dignity, human rights and 'natural law' a step further by adding the concept of duty. Within Catholic Social Teaching rights entail responsibility and duty (see chapter 5). The individual is thus obligated by this 'natural law' to make life choices in line with the teachings of the Church.

These conflicts are apparent in the negotiations towards the PDs on HIV & AIDS and as discussed in chapters 8 and 9, influence the text such that references to key populations are removed or minimal.

Following adoption of the Political Declaration on HIV & AIDS in 2016, a Holy See statements, indicated reservations on the text. Excerpts from the intervention, below, capture well how these areas of conflict between the traditional religio-cultural discourse and the theoretical frameworks underpinning public health, human rights and gender equality discourses operate at the UN. This statement

confirms that the sources of conflict are conceptual in nature as highlighted in italics:

> However, while discrimination and stigmatization must be combatted, it is of vital importance to distinguish between *policies that discriminate and stigmatize unjustly and those put in place to discourage risk-taking behaviours and to encourage responsible and healthy relationships, especially among youth*. In this regard, the Holy See continues to call attention to the undeniable fact that the only safe and completely reliable method of preventing the sexual transmission of HIV is abstinence before marriage and respect and mutual fidelity within marriage.
>
> The Holy See, in conformity with its nature and particular mission, especially keeping in mind the work of the Catholic Church in the field confronting HIV and the AIDS epidemic, wishes to make the following *reservations on some of the concepts* used in this Political Declaration:
>
> With reference to "gender", the Holy See understands the term to be grounded in the biological sexual identity and difference that is male or female. *Regarding the concept of "gender norms" the Holy See does not recognize the idea that gender is socially constructed*, rather gender recognizes the objective identity of the human person as born male or female.
>
> With respect to "comprehensive education" or "information" on sexual and reproductive health, the Holy See reiterates the *"primary responsibility" and the "prior rights" of parents when it comes to the education and upbringing of their children*, as enshrined, inter alia, in the Universal Declaration of Human Rights and the Convention on the Rights of the Child. In that sense, the Holy See wishes to underline the centrality of the family, as well as the role and rights and duties of parents to educate their children (Holy See 2016)

The texts in italics are examples of the concepts of NLCC and teaching of the Catholic Church on sexuality expressed in this intervention, which conflict with the CEGM and SDHIV theories outlined above that underpin the public health, human rights and gender equality discourses.

9.6.2.3 Group 3: Conflicts around secularism

Secularism is discussed in some detail in Chapter 6. The main definitions, assumptions and concepts of secularization theory underpinning secularism are not included in the mapping exercise because there are many different interpretations of secularization theory in the literature, and the way secularism operates in different countries is also quite different, as explained in chapter 6. There is no one overarching conceptual framework to describe secularism as it operates at the UN. It is, however, the dominant paradigm at the UN, and as explained in chapter 6 the form of secularism operational at the UN tends to be of the sort that is 'impermeable to evidence and argument', and characteristic of the 'oppressive ideologies' identified by Michael Freeden (Freeden 2006, 6).

There are two important points to take from the literature. Firstly, as Ager and Ager note, the development discourse is still firmly committed to modernity and secularism. Secondly, at the same time, within academic spheres 'political, social, and cultural thinking grapples with the consequence of its demise'(Ager and Ager 2016, 102). Secularism remains dominant as the modus operandi for most of the WEOG states at the UN, but this continues without any coherent theoretical framework underpinning how it should operate, nor with any recognition of the advances in academic thought that indicate secularism may no longer be an adequate framework with which to manage pluralism in an increasingly complex world.

The conflicts between this 'hard', or 'oppressive' type of secularism and other conceptual frameworks are not around the concepts or the content of the issues of gender, sexuality, marriage, family, HIV and SRHR. The conflict arises from the secularist position that the traditional religio-cultural discourse (or any other religious discourse) should not have a place at the table, nor should they be

brought to the table by any MS. The hard secularist position is that any religious discourse in public policy is inappropriate and unacceptable. This precludes any discussion on the content of a religious discourse, and whether it might have anything meaningful to bring to the discussion, or whether there might be an alternative religious discourse supportive of the public health, human rights and gender equality discourses. In this sense, secularism operates as an oppressive ideology at the UN.

Gaps in the PDs around key populations can be attributed to the exclusionary tactics of the proponents of the traditional religio-cultural discourse, who in this situation are using their interpretation of natural law and human rights as an oppressive ideology, according to Freeden's definition. Gaps in the PDs around the positive role a faith community can play in addressing the HIV epidemic and SRHR can be attributed to the exclusionary tactics of supporters of an oppressive ideology of hard secularism.

9.7 Conclusions

There is a clear shift in framing of women, girls and young people between PD2011 and PD2016, reflective of intensive work during the SDG process. The framing of issues and commitments on women and girls are much stronger and more detailed in PD2016 as a result of strategies developed during the negotiations towards the SGDs.

Member States and technical agencies have developed some successful strategies to respond to demands from supporters of the national sovereignty discourse for nationally defined key populations. These include supporting stronger data collection and disaggregation methods, and the development of detailed regional strategic plans on HIV & AIDS based on regional data, containing specific numerical targets.

There is no evidence of progress however, on the core areas of conflict on HIV, gender and SRHR and key populations, where the traditional religio-cultural discourse operates as an oppressive ideology and does not appear to draw on the

broader and richer theological discourses around natural law and human rights. The text on key populations remains limited and cautious.

Similarly, there also is no evidence of action to challenge the oppressive ideology of hard secularism, or to investigate how that might be contributing to gaps in the PDs and the polarization of issues within the negotiations.

Examination of the conflicts between the conceptual frameworks provides some insights into the underlying reasons for some of the conflicts. Chapter 10 will build on this understanding and seek to identify potential areas of synergy, common ground and strategies for moving forward.

Chapter 10. Analysis, Discussion and Recommendations

10.1 Introduction

The purpose of this chapter is to address research question 6: Are there ways in which the broad religious discourse and approaches might bring new insights to the negotiating table to address some of the areas of conflict and tension? In addition, section 10.3 addresses the question: What strategies are evident in the text of the PDs to address tensions between the discourses?

Several methods are employed to do this. This chapter draws on the analysis and conclusions presented in chapters 5-9 (which will not be repeated here) to conduct a final round of interdisciplinary analysis using Repko's methodology for identifying common ground and generating interdisciplinary understanding from which a series of recommendations are offered in section 10.4. The chapter closes with two short sections articulating the contribution this thesis makes to the field of HIV practice within the UN and to the discipline of practical theology.

This chapter also draws out strategies evident in PD2016 to counter some of the resistance from the traditional religio-cultural and national sovereignty discourses to public health, human rights and gender equality seen in PD 2011. Some of these have the potential to be expanded. In addition, examples from chapter 7 of how religion operates in the broader HIV response are re-examined in order to identify possible areas of common ground, entry points and approaches to reduce the tension and conflict around HIV and SRHR at the UN. Some of these insights have been identified by the experts in this field already and will be referenced. There is much ongoing work at the boundaries of these discourses to expand knowledge and create new spaces for dialogue that can be strengthened, funded and showcased.

10.2 Create or identify common ground

There are areas of potential synergy and common ground between the discourses evident from the conceptual mapping exercise discussed in chapter 9, these include:

10.2.1 Consensus on human rights

Elements of the traditional religio-cultural discourse are enshrined in the UDHR. A summary of examples includes: every person has inherent dignity and entitlement to human rights; the right to life itself; the family unit is central to society and should be respected and protected; parents play a critically important role in educating their children; and individuals should have the freedom to practice a religion of their choice. There is consensus across all stakeholders on these fundamental human rights. It is important not to lose sight of the broad areas of consensus when conflicts arise about how these are interpreted and applied.

10.2.2 Consensus on HIV policy and action

Consensus exists on much HIV policy and programmatic action. For example: the importance of preventing new HIV infections and scaling up access to HIV testing and treatment, especially for those left behind, including children; the importance of providing care and support to people living with HIV; the need for adequate funding for the HIV response, and the requirement that pharmaceutical companies provide affordable medications.

10.2.3 Consensus on sensitive issues

Consensus also exists on some of the more sensitive HIV issues: Firstly, the concept that men and women are different - that gender equality is not synonymous with sameness - is common to the conceptual frameworks. Women and men have equal rights, and on this there is also consensus (Council of Europe 1998). The conflict arises around the concept of social construction when the right to be different is introduced, but there are significant areas of commonality before that conflict is discussed.

Secondly, there are areas of synergy between the discourses around behaviour regarded as not acceptable. For example: Sexual and gender-based violence, forced sex, rape, including forced sex work, and sex with minors, stigma and discrimination towards people living with HIV (Parker and Aggleton 2003) (Catholic Church 1997a). Other areas of potential synergy include: The importance of community engagement and the involvement of PLHIV in decision making and programming; the need to promote social justice and to address the structural inequalities and structural injustices that drive vulnerability; grace, compassion and mercy (Parker and Aggleton 2003, Catholic Church 1997b, Council of Europe 1998, Clague 2011).

Grace as a concept in Christian teaching is the free bestowal of blessing upon sinners, received by faith alone- in covenants of grace,[35] (VanDrunen 2014, 16) and is discussed in chapter 7. This refers to Christian belief in God's infinite and gratuitous love and merciful compassion for every human, irrespective of their failings and sinful nature. Grace is not earned by good behaviour or religious performance; it is unconditional. In the context of the HIV response, theologies of grace emphasise the transformative power of God's presence among those dealing with the disease in ways that support human well-being, such as through building resilience, healing relationships, and overcoming injustices. Theologies of grace are common across the spectrum of religious discourse and are shared by supporters of both the traditional religio-cultural discourse and the broader religious discourse. Supporters of the traditional religious discourse tend to emphasise obedience and conformity to social norms derived from religious and moral laws and teachings, and God's judgement of sinners based upon their failure to reach required standards of behaviour, or their indifference to religious norms over their theologies of grace, especially in their negotiations at the UN. The dichotomy, or false dichotomy between theologies of grace and law in the context of HIV is discussed in Chapter 7 including work by several authors including David VanDrunen, Daryl Charles, Gillian Paterson, and others. This concept of grace is fundamental to the broad religious discourse on HIV and may

[35] **Ephesians 2:8-9** For by grace you are saved through faith, and this is not of yourselves, it is the gift of God; 9 it is not of works, so that no one can boast

itself be a bridge between two ends of a very wide spectrum of religious discourse on HIV because it is shared by all.

10.2.4 Draw on insights from experts

Repko is clear that the 'objective of creating common ground it not to eliminate tensions altogether between the insights of different disciplines, but to reduce the level of tension'(Repko 2008, 301). This is important because in the complex political arena of policy-making at the UN on HIV and SRHR the tensions are significant and longstanding. Any attempt to decrease these tensions and forge synergies will be helpful, but they are unlikely to be resolved easily or quickly. The SDGs demonstrate commitment to inclusivity and partnerships, which will require that the Member States of the UN find ways to include a plurality of voices. Some voices currently excluded from the discourse are those of key populations most at risk of HIV and others are representatives from the broader faith traditions.

To integrate the insights from the theoretical mapping of concepts and assumptions it is important to consider insights from experts working in the field. Ways suggested by Repko for expressing this integrated interdisciplinary understanding include proposing a new model or new metaphor, asking new questions or proposing a new process (Repko 2008, 311). I will apply these three approaches to generate the final recommendations of this thesis.

Literature reviews in chapters 3-7 contain insights from experts working at the boundaries of these discourses. In addition, examples of theological reflection and practical approaches are documented, which can support these potential synergies and from which some new thinking can emerge. This section provides examples of work in four areas that could have the potential to transform the global HIV response and contribute to unlocking some of the conflict and tension documented in this thesis. It could bring different religious perspectives to the table to counter the dominance of the traditional religio-cultural discourse in policy-making at the UN.

Chapter 7 documents the history of change and self-critical reflection by the Christian faith community supportive of the broad religious discourse on HIV. Supporters of this discourse include religious leaders and faith partners from all faith traditions. Whilst detailed analysis of their responses is beyond the scope of this thesis, the UN response must be pluralistic, inclusive and multifaith. UNAIDS in partnership with the IATF has contributed to building a multifaith network of religious leaders, champions and faith-based partners working on the SDGs and this thesis recommends that this network be drawn upon in responding to recommendations in the thesis. Member States, as the duty bearers who adopted the SDGs have the responsibility to evaluate and respond to recommendations emerging from research such as this.

History of the broad religious discourse discussed in chapter 7 demonstrates changes in the responses of the Christian faith community supportive of the broad religious discourse over time. This is important because the at the most conservative end of the spectrum of religious discourse, positions have not changed, but supporters have maintained their commitment to protect doctrine in the face of change and at the expense of grace. The broad religious discourse has worked to expand grace and be more inclusive. Kurian notes a change in the tone of the HIV response over time, from charity to humility, demonstrating an increased willingness to learn from those on the margins of society (Kurian 2016, viii) and to learn from, and be led by PLHIV. Manda documents the shift from a theology that views AIDS as a punishment from God to one that promotes and affirms life. Ethical values of ‘relationality, inclusivity, love, care and compassion’ are central to this approach (Manda and Haddad 2011, 201). Manning calls for more honesty about early failures and the flaws of faith responses and more mutual respect and accountability (Manning 2011).

The rich work of this constituency for over 30 years can be clustered into four areas: i) Theological reflection; ii) practical action, including health service delivery and local care and support; iii) the development of resource materials and training courses on HIV for faith communities; and iv) advocacy and policy. This advocacy has two target audiences a) ‘in-reach’- advocacy directed towards the faith community itself and b) ‘out-reach’- advocacy to policy makers on HIV.

This section, drawing on the expertise in the field, will highlight examples in these four areas, which are discussed in full in chapter 7 and annex 7.

10.2.5 Advocacy and Political Action

One important element of this advocacy by religious leaders and faith partners working on HIV and SRHR is to speak to and lead the faith community response in ways that are supportive of public health, human rights and gender equality. This strong supportive advocacy, and powerful statements from religious leaders and faith partners, demonstrate to the HIV community and international policy makers that there is another active faith discourse on HIV and SRHR and here is its strong message. Examples of these statements include the WCC Executive Committee statement on AIDS in 1986, which was ground-breaking in its language at the time (Kurian 2016, 7). This statement contains the main concepts of the broad religious discourse on HIV. This framing has been strengthened in the multifaith commitment of religious leaders at the High Level Religious Leaders' Summit in 2010 (EAA 2010) and the call to action in advance of the HLM in 2016 (Ecumenical Advocacy Alliance 2016a). Another multifaith statement emerged from an important meeting convened by UNFPA, held inside the UN itself, in parallel with the UN General Assembly Meetings in 2014 (UNFPA 2016, 79).

These broad faith partnerships include Catholic Church partners working on HIV and SRH and RR. This is important in the broad discourse because there is a plurality of voices within Catholicism. It is important to distinguish between the traditional religio-cultural discourse put forward at the UN and the much broader response of the Catholic Church partners working on HIV and SRHR.

10.2.6 Theological reflection

In three decades, many publications have been collected in the annotated bibliography of the CHART database (Haddad 2011). These and the publications of the WCC provide the theological framework for the broad religious discourse,

which is supportive of the conceptual frameworks outlined by the Council of Europe and Parker and Aggleton, described in chapter 4.

This theological reflection includes work to re-interpret religious texts and traditions in light of the HIV response to find texts and traditions supportive of public health, human rights and gender equality e.g. *Religion, Women's Health and Rights: Points of Contention and Paths of Opportunities*, (UNFPA 2016); work to explore human sexuality (Chitando and Njoroge 2016), to change toxic masculinities and patriarchy with transformative masculinities (Ezra and Sophie 2012); work to challenge social injustice and structural sins, to champion social justice, human rights and gender equality (Clague 2011, 292), to address sexual and gender-based violence (CHART 2011), and LGBT issues (Tulleken and Mokgethi-Heath 2016).

10.2.7 Resource materials for faith communities on HIV and SRHR

People living with HIV have led in the development of methodologies to enable faith communities to address the HIV epidemic. These include the SAVE methodology championed by Canon Gideon Byamugisha, now taught by Christian Aid and INERELA+ through the accompanying SAVE toolkit across the world (INERELA+ 2017). Reverend Christo Greyling developed the training course Channels of Hope, and World Vision has rolled this out across more than forty countries (World Vision 2013, 4). The Framework for Dialogue is a methodology to support structured dialogue at national level between networks of people living with HIV and religious leaders to address stigma and discrimination building on evidence from the national stigma index data collected by PLHIV (Ecumenical Advocacy Alliance 2011, GNP+ 2011). *Dignity Freedom and Grace* is a publication of theological reflections to support these dialogues (Paterson and Long 2016)

10.2.8 Practical action and service delivery

This is one of the largest contributions of the faith community on HIV and one of the strongest rationales for strengthening engagement between the public

health community and FBOs working in the HIV response. This work has been documented and discussed in chapter 7, annex 7, in *The Lancet Series* paper 1, (Olivier et al. 2015) and by the academic consortium of the PEPFAR/UNAIDS FBO Initiative (Blevins et al. 2017).

10.3 Strategies and ways forward

This section addresses the question: What strategies are evident in the text of the PDs to address tensions between the discourses?

There is a demonstrable shift between 2011 and 2016 from the portrayal of women and young people as passive, vulnerable and without agency towards a portrayal of them as people with agency and rights. Significant obstacles remain however, as PD2016 does not include the same level of detailed commitments on key populations as women and girls, and there are still significant elements on women, girls and young people included in Stragtegy2016, missing from PD2016.

Two strategies have proven partially effective in strengthening PD2016:

(i) To provide countries with solid data on national and regional epidemics, and to work closely with national and regional partners to develop specific HIV & AIDS strategies and plans (General Assembly Resolution 2016, 20).

Many countries do not have accurate data on the size of key populations at increased risk of HIV infection (see UNAIDS AIDSinfo) (UNAIDS 2017a).The technical agencies have helped countries strengthen national data collection on key populations. The availability of more accurate data on HIV rates among key populations makes it more difficult for MS to (a) deny there are key populations amongst whom HIV is a problem, and (b) define key populations according to national priorities based upon oppressive ideology rather than evidence.

Chapters 8 and 9 demonstrate that the traditional religio-cultural and national sovereignty discourses have limited the content and commitments of the four PDs in very significant ways. The impact of the traditional religio-cultural and

national sovereignty discourses is much greater than simply the number of times the words sovereignty, religion or abstinence appear in the text. Chapter 9 demonstrates that these discourses continue to shape the way women, young people and key populations are portrayed. The key populations of men who have sex with men, sex workers, people who inject drugs, transgender people and prisoners continue to be invisible, hidden in the term 'populations at higher risk of HIV infection'. Persistent, paternalistic portrayals of women and young people, and moralistic or judgemental statements about key populations undermine robust attempts to address social norms and the structural factors which maintain vulnerability as the status quo.

PD2016 is less compromised than earlier PDs, partly because PD2016 built on the strong and inclusive SDG negotiation process, which resulted in robust goals and targets around women and girls, gender and participation. The extensive human rights foundations to the SDGs have provided a precedent for MS to include stronger language on human rights in PD2016. There has been no significant progress however, in addressing the ideological battles around the structural drivers of HIV, the role of women, the family, young people, key populations, and criminalization.

(ii) The second strategy that helped to strengthen PD2016, which was also deployed in negotiations towards the SDGs, was to reintroduce the use of some of the language around family and religion claimed by the traditional religio-cultural discourse supporters. For example, in PD2016, 1 the term dignity is re-introduced (last mentioned in PD2001, 2) and PD2016, 10 mentions a 'virtuous cycle' of progress. These concepts are not expanded in PD2016, but mentioning these terms is a first step to broadening the discourse and reclaiming some of the concepts that have been lost to a much narrower interpretation put forward by supporters of the traditional religio-cultural discourse. This thesis recommends that this reclamation should be much more extensive, strategic and coordinated.

Similarly, strategies to reclaim concepts of rights, dignity and family in the HIV response should draw on the broad religious discourse to articulate religious and

theological support for public health measures based on evidence, rights and gender equality. These exist and have been well documented. They have been blocked from informing the negotiations by the dominance of hard secularism among the WEOG states, some of whom have funded their development and publication, but continue to insist that they should have no influence in the political negotiations.

This thesis recommends that a strategic coalition of MS, technical agencies and a broad coalition of FBOs supportive of evidence, rights and inclusive approaches to public health should work together to develop specific strategies and approaches to address these ongoing obstacles, drawing on learning from the broad religious discourse. Some of the questions in section 10.5 will contribute to develop this strategy.

10.4 Integrate insights and produce interdisciplinary understanding

Returning to Repko's final steps of the interdisciplinary research process, he suggests six possible ways to express interdisciplinary understanding. I propose to use three of these: Firstly to ask a new questions, secondly, propose a new process, and thirdly, to apply new understanding to the existing problems (Repko 2008, 311).

Recommendations

10.4.1 Ask new questions at the UN

WEOG member states should consider why only one very narrow religious perspective is present in negotiations at the UN: is it just about the privileged position of the Holy See, or does hard secularism play an equally important role in securing dominance of the traditional religio-cultural discourse over other perspectives?

WEOG member states should consider whether secularism is an appropriate approach to pluralism in today's complex world, where religion is an integral

part of many societies and is inextricably interwoven with the issues of HIV and SRHR.

WEOG Member States should consider whether attempts to exclude all religious perspectives from the dialogue - as advocated by hard secularism - achieve the objectives of a strong text on HIV and SRHR in politically negotiated documents, or is the result rather to create a vacuum into which the most conservative voices have freedom to expand? (Annex 10 articulates some of the losses and gains to selected paragraphs through the negotiation process, which illustrate something of the challenge to be overcome).

To what extent are the ‘no-go’ areas in negotiations and texts (e.g. to frame the factors which put key populations at risk of HIV infection and make commitments to address them) a reflection of the ‘no-go’ areas of hard secularism, that have led to the exclusion of a broader religious discourse and thus advanced the dominance of the traditional religio-cultural discourse?

Given that traditional religio-cultural approaches to marriage and family fuel tension, conflict and polarization at the UN, might approaches within the broader religious discourse on these issues help unlock the conflict?

This thesis has presented conceptual synergies between public health, human rights and gender equality discourses and the concepts and approaches of grace, social justice and structural injustice in the broader religious discourse. Why not try a different approach? Intentionally bring in religious perspectives that have been absent from the policy-making discourse at the UN on HIV and SRH for 15 years. Work actively to reduce the level of tension by expanding existing concepts and introducing new concepts; extend the dialogue across traditional disciplinary boundaries, drawing on longstanding work by experts in this field.

There are many examples of good interdisciplinary work that are crossing the boundaries of these discourses as documented in earlier sections of this chapter. These are on the fringes of the UN but are often dismissed as irrelevant to the content of the negotiations by WEOG negotiators and technical partners

supporting them at the UN. Given the negative influence of cultural and religious factors on debates at the UN it may appear counter-productive to give a hearing to alternative religious discourses. However, a greater understanding of the potential areas of synergy between religion and public health, human rights and gender equality might introduce new perspectives that could inform more balanced interventions and ultimately help achieve consensus.

10.4.2 Explore some new counter-intuitive processes

This section proposes some ways to draw on the broad religious discourse at the UN. This is not to suggest that the PDs be filled with religious text. Rather, the idea is to draw on this as a resource base in the same way that the HIV response draws on the research, literature and discipline of social science for example. The purpose is to inform PDs, which are based on public health, human rights and gender equality.

WEOG member states should actively engage with the broad spectrum of religious actors in their countries who are working on SRHR and HIV, particularly with those attempting to extend the discourse and expand theory by crossing the disciplinary boundaries.

Member states and technical agencies should strengthen or introduce ways that technical experts can learn more about these alternative religious approaches, which might help to unlock the tension at the UN on these sensitive issues e.g. theological reflection on concepts of sexuality, transformative masculinities, grace, social justice and structural injustice in light of human rights, gender equality, sexual and reproductive health and gender-based violence.

Member states at the UN sometimes invite representatives from civil society to be part of national delegations to bring specific expertise to the negotiations (e.g. People living with HIV or young people). They should consider inviting representatives of broader faith traditions, who are experts, with understanding of religious approaches that are supportive of public health, human rights and

gender equality in HIV and SRHR, onto national delegations to systematically and intentionally bring different perspectives into the negotiations.[36]

10.4.3 Apply the new understanding to the problem:

There is already much good work going on to foster dialogue on HIV and SRH with a broader constituency of religious actors, as this chapter has shown, but as yet it is not member state driven and is poorly funded and patchy. The dominance of hard secularism and secularization among WEOG makes this a 'no-go' area for many MS.

NORAD, UNFPA and UNAIDS have pioneered a number of important initiatives (explored in this thesis), to take these discussions further. However, these have been on the side-lines and funding is not available for expansion. The PEPFAR/UNAIDS FBO initiative has also begun to explore some of these areas within the Christian faith tradition. It must expand to become truly interfaith to have more significant impact, otherwise it risks becoming divisive.

This thesis recommends proactive investment in this work with the active participation of other member states to:

- Set up a series of 'Missions briefings' and work together to develop a strategic plan of engagement to address the areas of tension in negotiations on HIV and SRHR at the UN in a new and proactive way.
- Intentionally bring other perspectives from the broader religio-cultural discourse into the debate that are supportive of public health, human rights and gender equality. Include those who can provide examples of good practice and a broader interpretation of religious teachings to the narrow and legalistic approaches put forward by the traditional religio-cultural discourse supporters. This approach should be interfaith.

[36] One or two WEOG delegations did take up this idea in 2016 and there were at least two ordained ministers supportive of the broad, bridge-building discourse on national delegations to the 2016 HLM on HIV/AIDS.

- Support a strategically designed and well-planned range of interreligious side-events on HIV and SRHR at the UN to address issues of tension.
- Commission additional research and publications to address the gaps in knowledge.
- Develop and strengthen the strategic exchange on religion and development run by the UN System Staff College led by UNFPA, UNAIDS and UNHRC: to build religious literacy among diplomatic and development staff; to exchange understanding about the discourses and concepts; identify opportunities for collaboration; and build a strategy to shift the current conflicts and overcome the dominance of current ideologies.
- Evaluate what works and modify the strategy accordingly.

Final thoughts on the potential contributions of this thesis to practice at the UN and to the discipline of practical theology.

Contribution of the thesis to practice within the UN.

Drawing on the insights of experts in the field of HIV policy making at the UN some important insights emerge. Claire Dickinson and Kent Buse reviewed literature on HIV related policy change and offer three important observations: Firstly, that the literature supports the idea that ‘there is no one single determinant of policy, but rather that it emerges from the unique interaction and configuration of ***institutions, interests and ideas’***, and that analysis of these determinants will help to understand and address some of the bottlenecks ‘to developing and implementing evidence-informed policy’ (Dickinson and Buse 2008, 3). Secondly, that more attention is needed to understand HIV discourses, how and why they develop, influence social attitudes, ‘frame (and support or undermine) evidence-informed policy, and how they can be reframed to tell convincing stories to address the real drivers of the epidemic’ (Dickinson and Buse 2008, 13). Thirdly, that greater investment is needed in unravelling the politics including, ‘the role of interests and power in AIDS policy processes’ and greater collaboration established between researchers, people living with HIV, and policy makers (Dickinson and Buse 2008, 13). In the following year Buse et.al, went on to call for this policy analysis to ‘examine the role of culture and values systems and how they are expressed as beliefs, ideas and argument, as

well as international factors …affecting state sovereignty over policy processes' (Buse et al. 2009, 5). Finally, in 2015 the UNAIDS-*Lancet* 'Commission on Defeating AIDS—Advancing Global Health', Piot et. al. concluded that:

> appeals to state sovereignty are unconvincing. State sovereignty now operates in the context of international responsibilities, as expressed in the UN Charter…. As the present Secretary-General has repeatedly said, religious, cultural, and other views must be respected, but not where they seriously infringe the universal human rights belonging to individuals everywhere (Piot et al. 2015, 199).

This thesis responds directly to these challenges and questions in the following specific ways. It addresses a gap in the literature in this area on how religious discourse influences policy making on HIV at the UN and provides some convincing alternative discourses, practical examples and conceptual frameworks that might have some impact on the current areas where progress has stalled. It articulates:

- How the **institution** of the Holy See influences HIV policy at the UN. What its **interests** are and where its **ideas** come from.
- How and why it supports evidence-informed policy on HIV in some important areas but undermines it in others and how this leads to bottlenecks in the policy making arena on HIV prevention, key populations and comprehensive sexuality education in particular
- How this conservative religious discourse is taken up by some MS with a strong interest in protecting national sovereignty, which increases the power of both discourses in the political negotiation process on HIV policy at the UN and further contributes to undermining evidence informed and rights-based approaches HIV policy in the areas listed above.
- This analysis has described the role of religious 'culture and value systems' and how these have been expressed as 'beliefs, ideas and arguments' at the UN in ways which resonate with and support a national sovereignty discourse.

- Analysis has also examined the close and strong linkages between the Holy See's teaching on natural law and human rights, how this supports some human rights and evidence-based approaches to HIV policy making in important areas and identifies where the discourses diverge and where tension arises.

Chapter 7 tells a different and I think a convincing story of a much broader religious discourse on HIV, which also includes a broad range of Catholic voices as well as those from Protestant and other faith groups. It provides substantive examples of theological approaches to both HIV practice and policy which reframe the religious discourse on HIV from one of individual sin, blame and punishment, to one which addresses the structural drivers and social injustices that underpin vulnerability to HIV. It provides some important evidence of religious approaches and discourses that support human rights and evidence-based approach to HIV policy making.

I would argue that this broader religious discourse on HIV (which represents a wide spectrum of opinion) has the potential to unlock negotiations which have stalled by providing a range of ideas, and conceptual frameworks, which support human rights and evidence informed approaches to HIV.

This broader religious discourse has the potential to provide alternative constructions to the current dichotomies prevalent at the UN i.e., that it is either rights ***or*** religion, scientific evidence ***or*** faith, and that there is only ***one*** religious perspective on HIV (one which is not only unhelpful, but positively harmful). It provides evidence of responses to HIV led by faith groups that are supportive of both human rights ***and*** religious teachings; scientific evidence ***and*** faith; and projects and programmes that demonstrate results in line with the SDGs and UNAIDS strategies.

This thesis demonstrates that Member States and other institutions with a hard secularist position, who seek to remove all religious discourse from international public policy debate on HIV are unsuccessful. This is because other Member States do not separate religious teaching from state policy and these tend to be states where a strongly conservative religious position is dominant and where national sovereignty is important. I argue that in seeking to remove all religious

discourse from the policy making arena, the result has been to increase the space and power of the conservative religious and national sovereignty discourses and exclude from the debate religious beliefs, ideas, arguments, conceptual frameworks and examples of practice that might provide a helpful counterpoint and support the agenda of more secular states seeking to put forward human rights and evidence informed approaches to HIV. The arguments of secular Member States may be more acceptable and convincing (to Member States where religious belief is central) when supported by religious beliefs, ideas, arguments, practice examples and support from respected religious leadership. The art of diplomacy and democracy is surely to present not an '***either or' dichotomy***, but a '***both and' solution*** that will be acceptable to all partners and move the room towards consensus.

Contribution of this thesis to the discipline of practical theology:

Practical theology as defined by Bonnie Miller McLemore is:

> An activity of believers seeking to sustain a life of reflective faith in the everyday**, a method or way of understanding or analyzing theology in practice** used by religious leaders and by teachers and students across the theological curriculum, a curricular area in theological education focused on ministerial practice and sub specialties, and, finally an academic discipline pursued by a smaller set of scholars to support and sustain these first three enterprises (Miller-McLemore 2012, 5).

According to Miller-McLemore, most British authors, 'consider pastoral and practical theology as interchangeable, whilst they would prefer practical theology since it has developed broader recognition as a discipline that points beyond the Christian pastorate' (Miller-McLemore 2012, 5) (Pattison and Woodward 2000, 12)

I consider the pastoral and practical elements of theology to be distinctly different but very closely interlinked and mutually re-enforcing. For people living with HIV the critical pastoral question is whether their faith community will accept, welcome and care for them when they declare their HIV positive

status, or whether they will be rejected, stigmatized and judged. In the policy making arena, which speaks to questions of practical theology there is active debate about the value of allowing religious discourse into the policy making space.

This thesis responds directly to some of these challenges and questions in the following specific ways:

- A wide range of theological conceptual frameworks underpin a wide-spectrum of religious discourses on HIV and AIDS. This thesis has documented these and demonstrated how this wide range of discourses and some of the conceptual frameworks that underpin them influence both pastoral care and public policy on HIV.
- This wide spectrum of religious discourses on HIV contains two very different polarized discourses at its extremes. At one end of the spectrum theologies of law, sin and judgement predominate, based on a narrow interpretation of natural law theory and influenced by early theological discourses of AIDS as a punishment from God for individual sin. Pastoral responses at this end of the spectrum are characterized by a focus on individual sin and programmes aimed at rescuing people from sinful lifestyles, including conversion therapy. They are generally experienced by people living with HIV as stigmatizing, discriminatory and judgmental. These would be known as very conservative religious approaches to HIV.
- Along the spectrum, more liberal religious approaches are increasingly influenced by theologies of grace, social justice, and the association between concepts of human rights and human dignity. These focus less on individual sin, and more on the structural injustices which make individuals vulnerable to HIV infection and its consequences and go as far as to call out stigma and silence on social and gender injustice/inequity as sin.
- This thesis has both documented and demonstrated how religious and cultural beliefs and attitudes (informed by underlying conceptual frameworks) influence not only pastoral care, practice and community attitudes, but also how those beliefs, attitudes and practices influence

public policy at national and international level on HIV through institutions, interests and ideas.

- The evidence presented in this thesis supports the idea of a cycle of influence: religious and cultural beliefs influence attitudes which have an influence on public policy, programming and practice. Conversely public policy can influence programming, practice, attitudes as well as cultural and religious beliefs.
- This thesis demonstrates that in the policy making arena on HIV at the UN, only one very narrow conservative end of the broad spectrum of religious discourse on HIV has a place at the table- and influences public policy on HIV.
- The evidence presented demonstrates that to limit religious engagement in public policy making to one voice (particularly when this one voice is a conservative and legalistic voice) has had a limiting and damaging impact on HIV policy, with a knock-on effect on programming, practice and attitudes.
- This is an important finding for the discipline of practical theology, which seeks to advocate for a broader role for religious discourse and voice in public debate in the face of a harder secularist approach, which seeks to eliminate all religious discourse from public policy debate. The thesis provides robust evidence, generated through a sound research methodology to inform public debate on the importance of bringing a broader range of religious discourses to the table.

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Annexes

Annex 1: Conceptual mapping

Discipline or theory	Definitions	Assumptions	Concepts- elementary building blocks of theory e.g. concept of class/gender/race/socioeconomic status	
Gender theory-conceptual Framework EC 1998	Gender equality means accepting and valuing equally the differences between women and men and the diverse roles they play in society. Gender equality includes the right to be different Gender equality means discussing how it is possible to go further, to change the structures in society which contribute to maintaining the unequal power relationships between women and men	Men and women are different Gender equality is not synonymous with sameness Gender is a socially constructed definition of women and men Men and women have equal rights	Gender is not only a socially constructed definition of women and men, it is a socially constructed definition of the relationship between the sexes. This construction contains an unequal power relationship with male domination and female subordination in most spheres of life Gender equality means an equal visibility, empowerment and participation of both sexes in all spheres of public and private life Gender equality is the opposite of gender inequality, not of gender difference, and aims to promote the full participation of women and men in society Gender equality is not synonymous with sameness Gender equality must be constantly fought for, protected and promoted - like human rights, of which it is an integral part Women's rights as human rights This includes effectively respecting, protecting and promoting the human rights of both women and men and, by taking the necessary measures, enabling both women and men to enjoy fully these rights. It also means combating interferences with women's liberty and dignity (combating violence against and trafficking in women or forced prostitution, promoting free choice in matters of reproduction and lifestyles, addressing the specific problems of migrant and minority women) Another very important target for gender equality is the individual's economic independence	(Council of Europe 1998, 7-9)

Discipline or theory	Definitions	Assumptions	Concepts- elementary building blocks of theory e.g. concept of class/gender/race/socioeconomic status	
			Education is a key target for gender equality as it involves the ways in which societies transfer norms, knowledge and skills The last target to be mentioned is women's and men's common acknowledgement of the need to remove imbalances in society and their shared responsibility in doing so	
HIV Stigma and discrimination conceptual framework	Defines stigma as 'an attribute that is significantly discrediting' which, in the eyes of society, serves to reduces the person who possesses it. (Goffman, 1963, in Parker and Aggleton 2003) Discrimination: More recent sociological analyses of discrimination, however, ''concentrate on patterns of dominance and oppression, viewed as expressions of a struggle for power and privilege'' (Marshall, 1998 in Parker and Aggleton, 2003)	Stigma and stigmatization not merely as an isolated phenomenon, or expressions of individual attitudes or of cultural values, but as central to the constitution of the social order Power therefore stands at the heart of social life and is used to legitimize inequalities of status within the social structure	To conceptualize stigma and stigmatization as intimately linked to the reproduction of social difference. Stigma feeds upon, strengthens and reproduces existing inequalities of class, race, gender and sexuality Stigma is conceptualized by society on the basis of what constitutes 'difference' or 'deviance', and that it is applied by society through rules and sanctions resulting in what he described as a kind of 'spoiled identity' for the person concerned (Goffman, 1963 in Parker and Aggleton, 2003) Thus stigma, understood as a negative attribute, is mapped onto people, who in turn by virtue of their difference, are understood to be negatively valued in society Much work has tended to focus on stereotyping rather than on the structural conditions that produce exclusion from social and economic life Vast majority of interventions focused on… increasing 'tolerance' of people with AIDS on the part of different segments of the 'general population' To move beyond the limitations of current thinking in this area, we need to reframe our understandings of stigmatization and discrimination to conceptualize them as social processes that can only be understood in relation to broader notions of power and	(Parker and Aggleton 2003, 13)

Discipline or theory	Definitions	Assumptions	Concepts- elementary building blocks of theory e.g. concept of class/gender/race/socioeconomic status	
			domination. In our view, stigma plays a key role in producing and reproducing relations of power and control. It causes some groups to be devalued and others to feel that they are superior in some way. Ultimately, therefore, stigma is linked to the workings of social inequality Throughout much of the developing world, for example, bonds and allegiances to family, village, neighbourhood and community make it obvious that stigma and discrimination, when and where they appear, are social and cultural phenomena linked to the actions of whole groups of people, and are not simply the consequences of individual behaviour. 'subjectification', or social control exercised not through physical force, but through the production of conforming subjects and docile bodies. He highlighted how the social production of difference (what Goffman and the US sociological tradition more typically defined as deviance) is linked to established regimes of knowledge and power. The so-called unnatural is necessary for the definition of the natural, the abnormal is necessary for the definition of normality, and so on While Goffman's work on stigma hardly even mentions the notion of power, and Foucault's work on power seems altogether unconcerned with stigma in and of itself, when read together their two bodies of work offer a compelling case for the role of culturally constituted stigmatization (i.e., the production of negatively valued difference) as central to the establishment and maintenance of the social order While 'rule' is based on direct coercion, 'hegemony' is achieved via a complex interlocking of political, social and cultural forces which organize dominant meanings and values across the social field in order to legitimize the structures of social inequality, even to those who are the objects of domination (Gramsci, 1970; Williams, 1977, 1982, in Parker and Aggleton, 2003)	

Discipline or theory	Definitions	Assumptions	Concepts- elementary building blocks of theory e.g. concept of class/gender/race/socioeconomic status	
			Ultimately, together with a new emphasis on community mobilization aimed at unleashing resistance to stigmatization and discrimination, structural interventions aimed at developing a rights-based approach to reducing HIV and AIDS-related stigmatization and discrimination should be a high priority in order to create a transformed social climate in which stigmatization and discrimination themselves will no longer be tolerated. Within such a framework, discrimination becomes a clear breach of a basic human rights obligation—a breach that, when concretized in civil rights legislation, can effectively impede and prohibit the exercise of HIV and AIDS related stigmatization and discrimination	
Natural Law (Catholic Theology)	CC 2334 "In creating men 'male and female,' God gives man and woman an equal personal dignity."119 "Man is a person, man and woman equally so, since both were created in the image and likeness of the personal God (p120)	CC 2333 Everyone, man and woman, should acknowledge and accept his sexual identity. Physical, moral, and spiritual difference and complementarity are oriented toward the goods of marriage and the flourishing of family life. The harmony of the couple and of society depends in part on the way in which the complementarity, needs, and mutual support between the sexes are lived out.	CC 2335 Each of the two sexes is an image of the power and tenderness of God, with equal dignity though in a different way. The union of man and woman in marriage is a way of imitating in the flesh the Creator's generosity and fecundity: "Therefore a man leaves his father and his mother and cleaves to his wife, and they become one flesh."121 All human generations proceed from this union CC 2352 By masturbation is to be understood the deliberate stimulation of the genital organs in order to derive sexual pleasure. "Both the Magisterium of the Church, in the course of a constant tradition, and the moral sense of the faithful have been in no doubt and have firmly maintained that masturbation is an intrinsically and gravely disordered action."138 "The deliberate use of the sexual faculty, for whatever reason, outside of marriage is essentially contrary to its purpose." For here sexual pleasure is sought outside of "the sexual relationship which is demanded by the moral order and in which the total meaning of mutual self-giving and human procreation in the context of true love is achieved." 2355 Prostitution does injury to the dignity of the person who engages in it, reducing the person to an instrument of sexual pleasure. The one who pays sins gravely against himself: he violates the chastity to	(Catholic Church 1997a)

Discipline or theory	Definitions	Assumptions	Concepts- elementary building blocks of theory e.g. concept of class/gender/race/socioeconomic status	
			which his Baptism pledged him and defiles his body, the temple of the Holy Spirit.140 Prostitution is a social scourge. It usually involves women, but also men, children, and adolescents (The latter two cases involve the added sin of scandal.). While it is always gravely sinful to engage in prostitution, the imputability of the offense can be attenuated by destitution, blackmail, or social pressure. 2356 Rape is the forcible violation of the sexual intimacy of another person. It does injury to justice and charity. Rape deeply wounds the respect, freedom, and physical and moral integrity to which every person has a right. It causes grave damage that can mark the victim for life. It is always an intrinsically evil act. Graver still is the rape of children committed by parents (incest) or those responsible for the education of the children entrusted to them. 2358 The number of men and women who have deep-seated homosexual tendencies is not negligible. This inclination, which is objectively disordered, constitutes for most of them a trial. They must be accepted with respect, compassion, and sensitivity. Every sign of unjust discrimination in their regard should be avoided. These persons are called to fulfill God's will in their lives and, if they are Christians, to unite to the sacrifice of the Lord's Cross the difficulties they may encounter from their condition. 2359 Homosexual persons are called to chastity. By the virtues of self-mastery that teach them inner freedom, at times by the support of disinterested friendship, by prayer and sacramental grace, they can and should gradually and resolutely approach Christian perfection 2360 Sexuality is ordered to the conjugal love of man and woman. In marriage the physical intimacy of the spouses becomes a sign and pledge of spiritual communion. Marriage bonds between baptized persons are sanctified by the sacrament.	

Discipline or theory	Definitions	Assumptions	Concepts- elementary building blocks of theory e.g. concept of class/gender/race/socioeconomic status	
			2361 "Sexuality, by means of which man and woman give themselves to one another through the acts which are proper and exclusive to spouses, is not something simply biological, but concerns the innermost being of the human person as such. It is realized in a truly human way only if it is an integral part of the love by which a man and woman commit themselves totally to one another until death. 2363 The spouses' union achieves the twofold end of marriage: the good of the spouses themselves and the transmission of life. These two meanings or values of marriage cannot be separated without altering the couple's spiritual life and compromising the goods of marriage and the future of the family. The conjugal love of man and woman thus stands under the twofold obligation of fidelity and fecundity.	

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Annex 2.1 Colour coding of text of discourses in the political declarations on HIV & AIDS

(a) Paragraphs in which the biomedical discourse is dominant

2011, 66. **Commit to accelerate efforts to achieve the goal of universal access to antiretroviral treatment for those eligible based on World Health Organization HIV treatment guidelines that indicate timely initiation of quality assured treatment for its maximum benefit, with the target of working towards having 15 million people living with HIV on antiretroviral treatment by 2015** (General Assembly Resolution, 2011)

2016, 60. (a) **Commit to 90-90-90 treatment targets,2 and to ensuring that 30 million people living with HIV access treatment by 2020 with special emphasis on providing 1.6 million children (0-14 years of age)** (General Assembly Resolution, 2016) **with antiretroviral therapy by 2018 and that children, adolescents and adults living with HIV know their status and are immediately offered and sustained on affordable and accessible quality treatment to ensure viral load suppression and underscore in this regard the urgency of closing the testing gap** (General Assembly Resolution, 2016)

(b) Paragraphs in which the human rights and gender discourse is dominant.

2016, 61. (a) **Recognize that unequal socioeconomic status of women compromises their ability to prevent HIV or mitigate the impact of AIDS and acknowledge the mutually reinforcing links between the achievement of gender equality and the empowerment of all women and girls and the eradication of poverty, reaffirm that the promotion and protection of, and respect for, the human rights and fundamental freedoms of women, should be mainstreamed into all policies and programmes aimed at the eradication of poverty** (General Assembly Resolution, 2016);

2016, 61. (c) **Pledge to eliminate gender inequalities and gender-based abuse and violence, increase the capacity of women and adolescent girls to protect themselves from the risk of HIV infection, principally through the provision of health care and services, including, inter alia, sexual and reproductive health, as well as full access to comprehensive information and education, ensure that women can exercise their right to have control over, and decide freely and responsibly on, matters related to their sexuality, including their sexual and reproductive health, free of coercion, discrimination and violence, in order to increase their ability to protect themselves from HIV infection, and take all necessary measures to create an enabling environment for the empowerment of women and to strengthen their economic independence, and, in this context, reiterate the importance of the role of men and boys in achieving gender equality** (General Assembly Resolution, 2016)

(c) Paragraphs in which the national sovereignty discourse is dominant.

2016, 4. **Reaffirm the sovereign rights of Member States, as enshrined in the Charter of the United Nations, and the need for all countries to implement the commitments and pledges in the present Declaration consistent with national laws, national development priorities and international human rights** (General Assembly Resolution 2016, 4)

(d) Paragraphs in which the traditional religious discourse is dominant

2011, 43. **Reaffirm the central role of the family, bearing in mind that in different cultural, social and political systems various forms of the family exist, in reducing vulnerability to HIV, inter alia in educating and guiding children, and take account of cultural, religious and ethical factors in reducing the vulnerability of children and young people by ensuring access of both girls and boys to primary and secondary education, including HIV and AIDS in curricula for adolescents, ensuring safe and secure environments especially for young girls, expanding good-quality youth friendly information and sexual health education and counselling services, strengthening reproductive and sexual health programmes, and involving families and young people in planning, implementing and evaluating HIV and AIDS prevention and care programmes, to the extent possible; (**General Assembly Resolution, 2011)

(e) A mixed paragraph draws out the multifaceted nature of the AIDS epidemic and the need for a multi-sectoral response - there is no apparent conflict here.

2001, 27. Welcoming the progress made in some countries **to contain the epidemic,** particularly through: **strong political commitment and leadership at the highest levels, including community leadership; effective use of available resources** and traditional medicines; **successful prevention, care, support and treatment strategies**; **education and information initiatives; working in partnership with communities, civil society, people living with HIV/AIDS and vulnerable groups;** and **the active promotion and protection of human rights;** and recognizing the importance of sharing and building on our collective and diverse experiences, through regional and international cooperation including North-South, South-South and triangular cooperation (General Assembly Resolution, 2001);

(f) Public health, biomedical discourse frequently appears together with the human rights and gender discourse

2016, 44. **Express grave concern that despite a general decline in discriminatory attitudes and policies towards people living with, presumed to be living with, at risk of, and affected by HIV, including those co-infected by TB, particularly in high TB/HIV burdened countries, discrimination continues to be reported, and that restrictive legal and policy frameworks,**

including related to HIV transmission, continue to discourage and prevent people from accessing prevention, treatment, care and support services;

2016, 47. Note with grave concern that the holistic needs and human rights of people living with, at risk of, and affected by HIV, and young people, remain insufficiently addressed because of inadequate integration of health services, including sexual and reproductive health-care and HIV services, including for people who have experienced sexual or gender-based violence, including post-exposure prophylaxis, legal services and social protection; (General Assembly Resolution, 2016)

(g) The traditional religio-cultural discourse appears together with the national sovereignty discourse

2001, 20. Emphasizing the important role of cultural, family, ethical and religious factors in the prevention of the epidemic and in treatment, care and support, taking into account the particularities of each country as well as the importance of respecting all human rights and fundamental freedoms (General Assembly Resolution, 2001)

(h) Traditional religio-cultural discourse and national sovereignty discourses qualify public health and rights-based approaches to HIV prevention

2011, 59. Commit to redouble HIV prevention efforts by taking all measures to implement comprehensive, evidence-based prevention approaches, taking into account local circumstances, ethics and cultural values, including through, but not limited to:

(c) Reducing risk-taking behaviour and encouraging responsible sexual behaviour including abstinence, fidelity and consistent and correct use of condoms;

(d) Expanding access to essential commodities, particularly male and female condoms and sterile injecting equipment

(h) Giving consideration, as appropriate, to implementing and expanding risk and harm reduction programmes, taking into account the WHO, UNODC, UNAIDS Technical Guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users in accordance with national legislation; (General Assembly Resolution, 2011)

(i) Traditional religio-cultural discourse and national sovereignty discourse qualify human rights discourse

2011, 38. **Reaffirm the commitment to fulfil obligations to promote universal respect for and the observance and protection of all human rights and fundamental freedoms for all in accordance with the Charter of the United Nations, the Universal Declaration of Human Rights and other instruments relating to human rights and international law; and emphasize the importance of cultural, ethical and religious values, the vital role of the family and the community and in particular people living with and affected by HIV, including their families, and the need to take into account the particularities of each country in sustaining national HIV and AIDS responses, reaching all people living with HIV, delivering HIV prevention, treatment, care and support and strengthening health systems, in particular primary health care;** (General Assembly Resolution, 2011)

(j) Traditional religious discourse qualifies a public health and human rights paragraph

2016, 62. (c) **Commit to accelerate efforts to scale up scientifically accurate age-appropriate comprehensive education, relevant to cultural contexts, that provides adolescent girls and boys and young women and men, in and out of school, consistent with their evolving capacities, with information on sexual and reproductive health and HIV prevention, gender equality and women's empowerment, human rights, physical, psychological and pubertal development and power in relationships between women and men, to enable them to build self-esteem, informed decision-making, communication and risk reduction skills and develop respectful relationships, in full partnership with young persons, parents, legal guardians, caregivers, educators and health-care providers, in order to enable them to protect themselves from HIV infection;** (General Assembly Resolution, 2016)

Annex 2.2: Charts

Chart 1: Frequency (stacked) of socio-political terms in UN PDs on HIV & AIDS 2001-2016

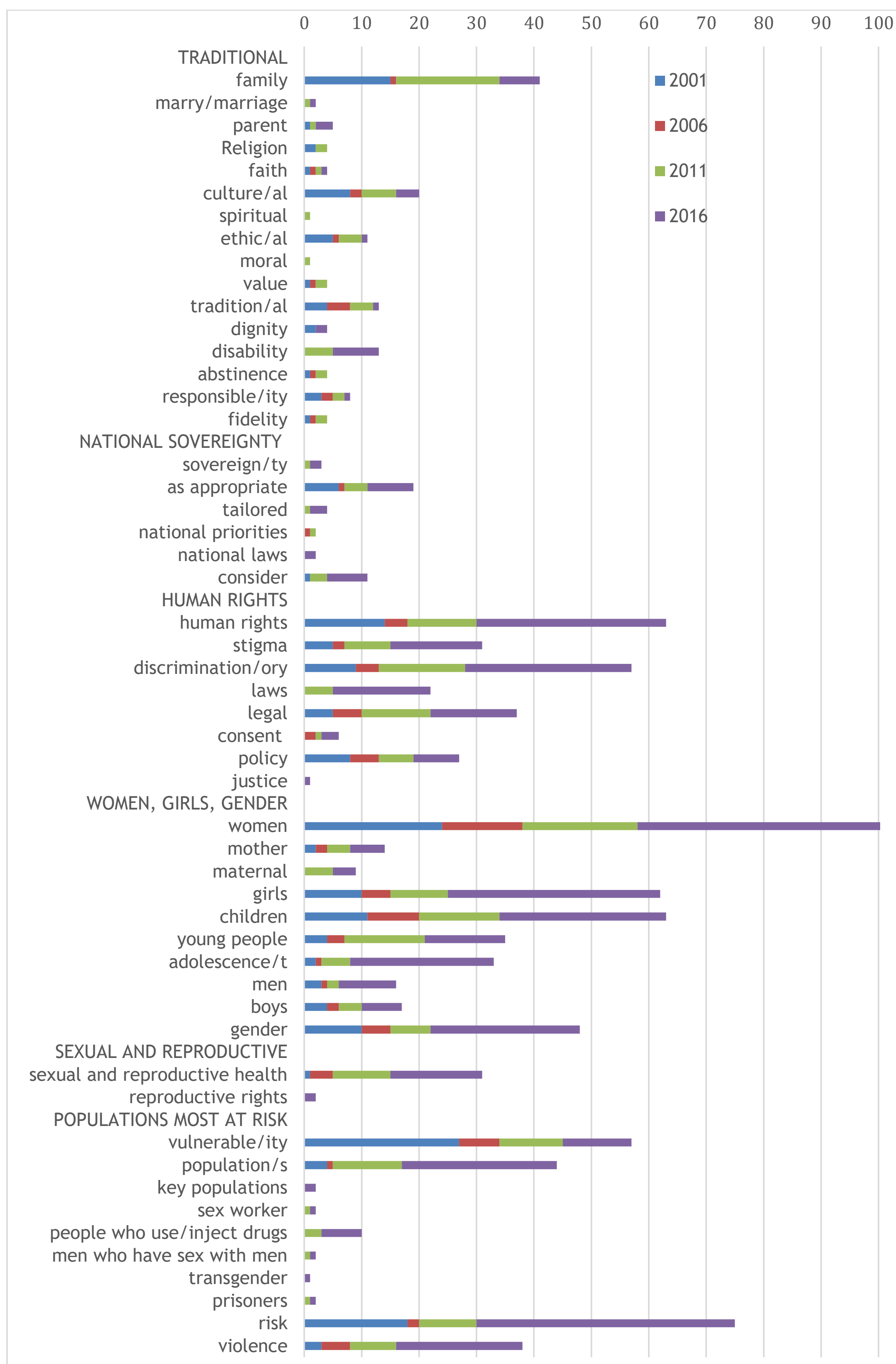


Chart 2: Frequency (stacked) of biomedical terms in UN PDs on HIV & AIDS 2001-2016

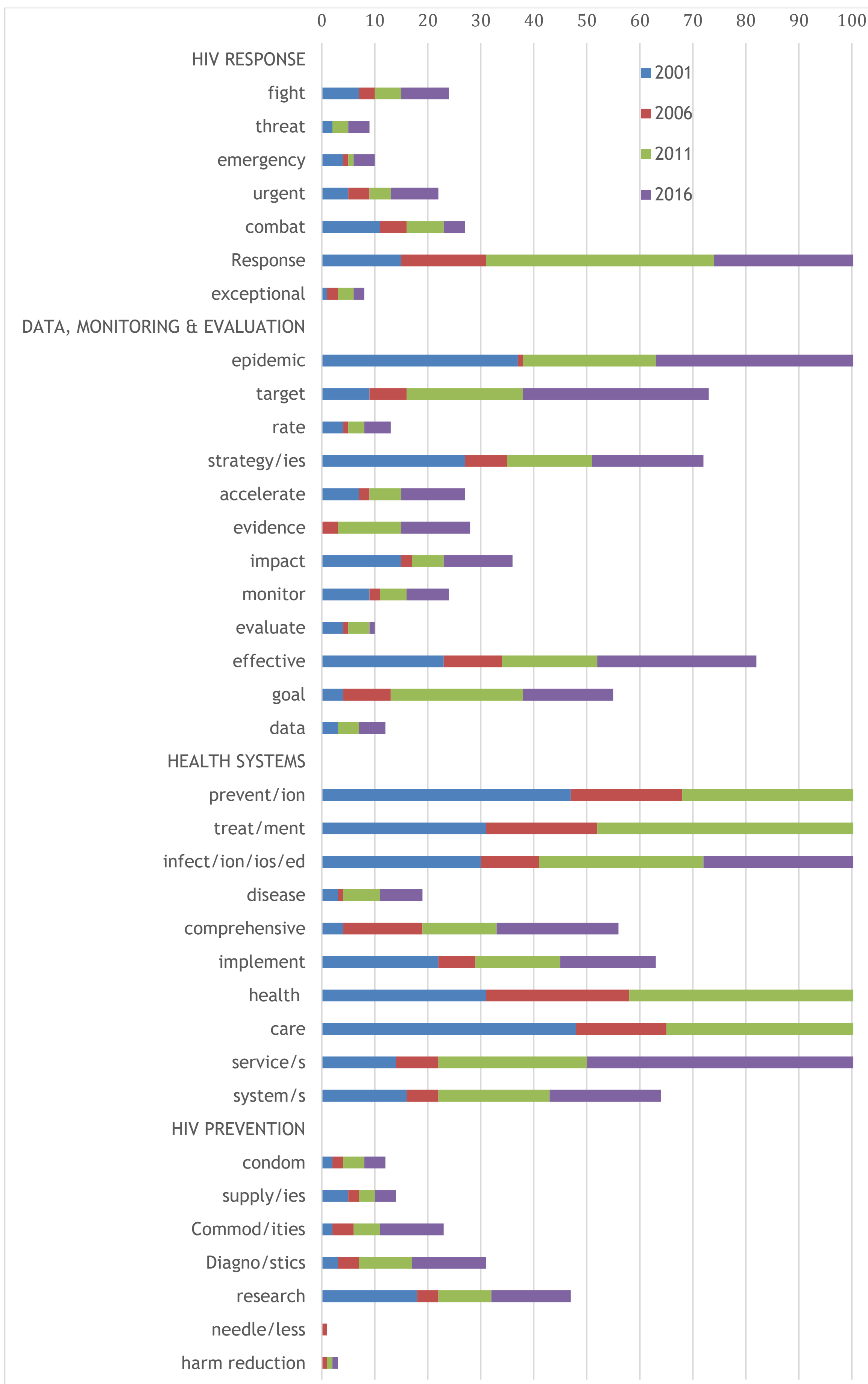


Chart 3: Frequency of socio-political terms in UN PDs on HIV & AIDS 2001-2016

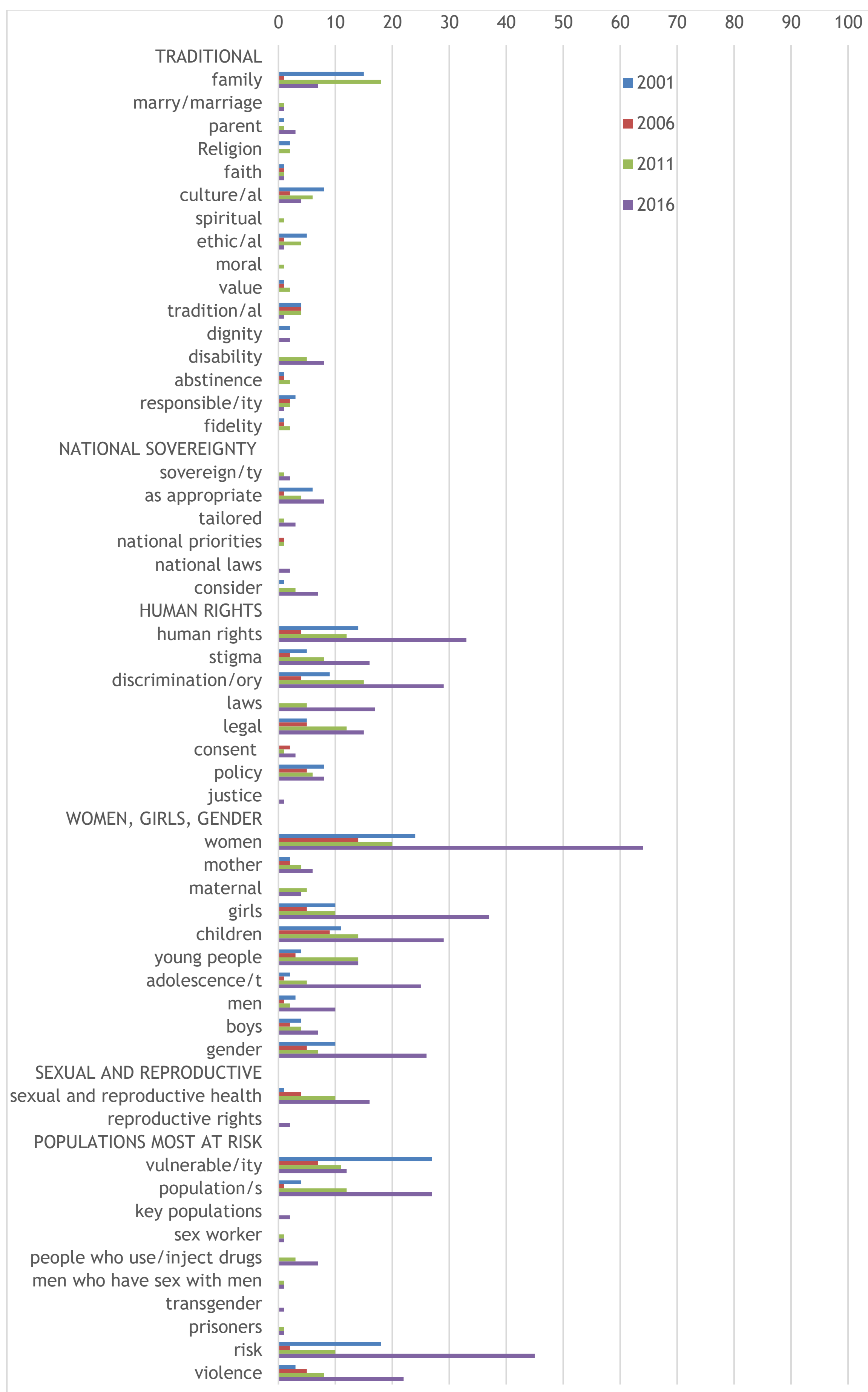
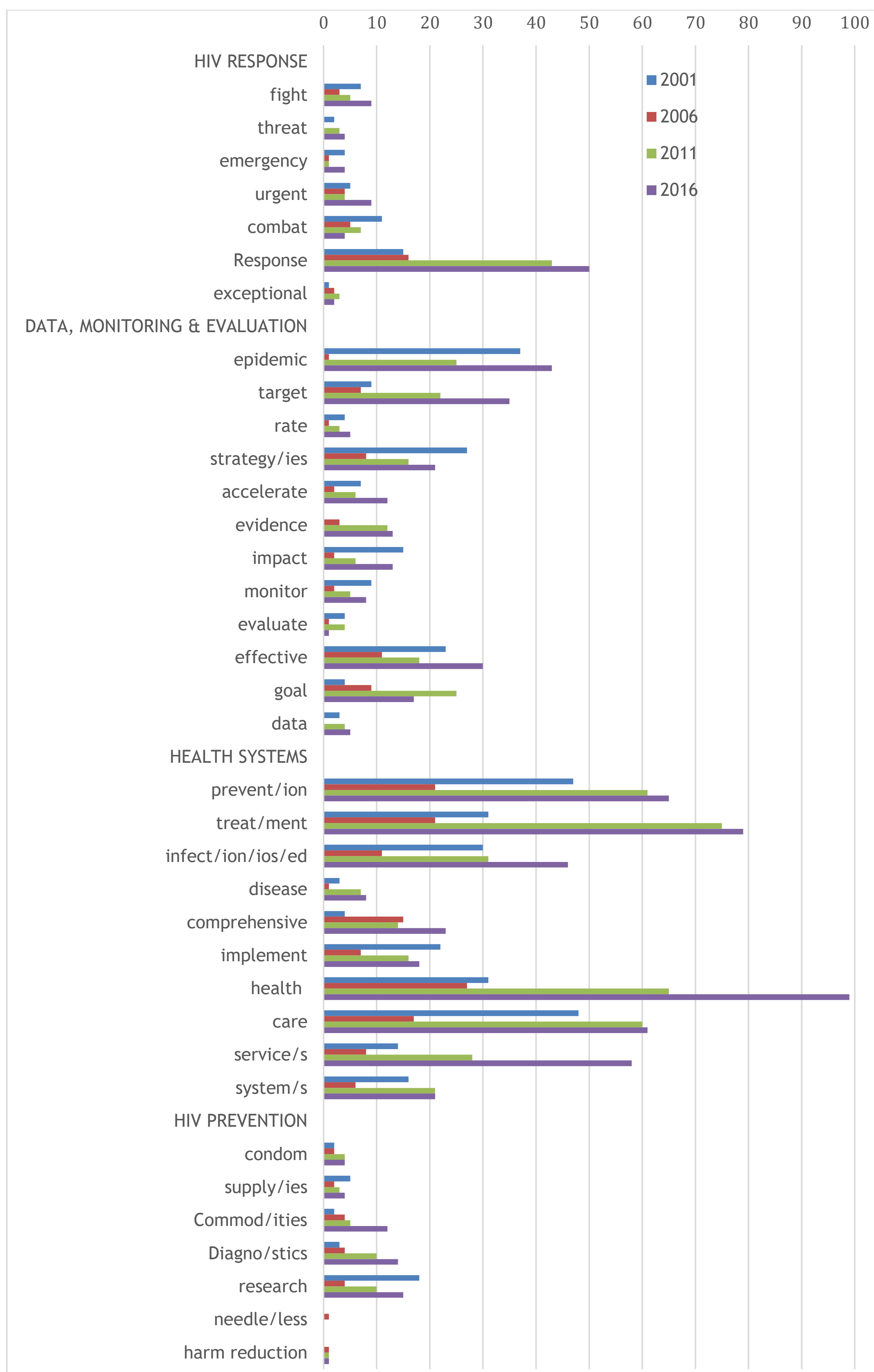


Chart 4: Frequency of biomedical terms in UN PDs on HIV & AIDS 2001-2016



Annex 3: Public health and biomedical discourse

This annex should be read in conjunction with chapter 3 and provides additional information to support section 3.2 and section 3.4 Development and debates.

Goals and targets

The specific goals and targets, to be achieved by 2020 in order to end AIDS as a public health threat by 2030 as set out in both UNAIDS and WHO strategies include:

Goals (UNAIDS 2015c, 15)

- Fewer than 500 000 people newly infected with HIV
- Fewer than 500 000 people dying from AIDS-related causes
- Elimination of HIV-related discrimination

Targets (UNAIDS 2015c, 8)

- Target 1: 90 percent of people (children, adolescents and adults) living with HIV know their status, 90 percent of people living with HIV who know their status are receiving treatment and 90 percent of people on treatment have suppressed viral loads.
- Target 2: Zero new HIV infections among children and mothers are alive and well.
- Target 3: 90 percent of young people are empowered with the skills, knowledge and capability to protect themselves from HIV.
- Target 4: 90 percent of women and men, especially young people and those in high-prevalence settings, have access to HIV combination prevention and sexual and reproductive health services.
- Target 5: 27 million additional men in high-prevalence settings are voluntarily medically circumcised, as part of integrated sexual and reproductive health services for men.
- Target 6: 90 percent of key populations, including sex workers, men who have sex with men, people who inject drugs, transgender people and prisoners, as well as migrants, have access to HIV combination prevention services for men.
- Target 7: 90 percent of women and girls live free from gender inequality and gender-based violence to mitigate the risk and impact of HIV
- Target 8: 90 percent of people living with, at risk of and affected by HIV report no discrimination, especially in health, education and workplace settings.
- Target 9: Overall financial investments for the AIDS response in low- and middle-income countries reach at least US$ 30 billion, with continued increase from the current levels of domestic public sources.
- Target 10: 75 percent of people living with, at risk of and affected by HIV, who are in need, benefit from HIV-sensitive social protection.

Result Areas

Strategy2016 puts forward eight result areas clustered under five of the SDGs (UNAIDS 2015c, 10, 11), these include:

Good health and well-being (SDG 3)

- Children, adolescents and adults living with HIV access testing, know their status and are immediately offered and sustained on affordable quality treatment
- New HIV infections among children eliminated and their mother's health and well-being sustained

Reduced inequalities (SDG 10)

- Young people, especially young women and adolescent girls, access combination prevention services and are empowered to protect themselves from HIV
- Tailored HIV combination prevention services are accessible to key populations, including sex workers, men who have sex with men, people who inject drugs, transgender people and prisoners, as well as migrants

Gender equality (SDG 5)

- Women and men practice and promote healthy gender norms and work together to end gender-based, sexual and intimate partner violence to mitigate risk and impact of HIV

Peace, justice and strong institutions (SDG 16)

- Punitive laws, policies, practices, stigma and discrimination that block effective responses to HIV are removed

Partnerships for the goals (SDG 17)

- AIDS response is fully funded and efficiently implemented based on reliable strategic information
- People-centred HIV and health services are integrated in the context of stronger systems for health

The WHO strategy has five strategic directions (WHO 2016b, 27):

- Strategic direction 1: Information for focused action (know your epidemic and response).
- Strategic direction 2: Interventions for impact (covering the range of services needed).
- Strategic direction 3: Delivering for equity (covering the populations in need of services).
- Strategic direction 4: Financing for sustainability (covering the financial costs of services).
- Strategic direction 5: Innovation for acceleration (looking towards the future)

UNAIDS Strategic direction one: HIV prevention - a technical package

In their technical strategies, WHO and UNAIDS advocate the implementation of a core package of combination HIV prevention (WHO 2016b, 34, UNAIDS 2016d, 7) and treatment interventions (WHO 2016b, 38, UNAIDS 2016a) to address some of the specific vulnerabilities highlighted above and end the AIDS epidemic as a public health threat by 2030. These interventions are based on scientific evidence of what works to reduce new HIV infections. The prevention framing is particularly important to this thesis as there is conflict and tension between some of the elements of the prevention strategy and a traditional religio-cultural discourse.

For HIV prevention, in order to achieve the targets set out in Strategy2016 and subsequently the PD, UNAIDS has identified gaps in current HIV prevention activities and defined 'combination prevention' approaches and actions that need to be taken (UNAIDS 2016d). This includes biomedical, behavioural and structural elements to HIV prevention. The actions must be tailored to the needs of specific populations most at risk of HIV infection and implemented in the geographic locations where the majority of these people are found in each country.

To reduce new HIV infections to below 500,000 by 2020 there are five pillars of action: Firstly, comprehensive sexuality education, economic empowerment activities and access to sexual and reproductive health services for young women, adolescent girls and their male partners in high prevalence locations. Secondly, evidence-informed and human rights-based HIV prevention programmes for key populations, including dedicated services and community mobilization and empowerment. Thirdly, strengthened national condom programmes, including procurement, distribution, social marketing, private-sector sales and demand creation. Fourthly, voluntary medical male circumcision in priority countries that have high levels of HIV prevalence and low levels of male circumcision, as part of wider sexual and reproductive health service provision for boys and men. Finally pre-exposure prophylaxis for population groups at higher risk of HIV infection (UNAIDS 2016d, 10).

For each of these pillars there are also a set of specific actions that need to be taken, based on the evidence of which actions reduce new HIV infections. These are supported by the recommendations of Lancet Commission Report *Defeating AIDS—advancing global health*, and include: to 'address criminalization, stigma and discrimination using practical approaches to change laws, policies, and public attitudes that violate human rights'(Piot et al. 2015, 5). Cultural, social and behaviour norms are also to be tackled. These create stigma, drive punitive legislation, restrict the access of young people and women to information and services to protect themselves from HIV infection and foster homophobia and stigma in health-care settings. All of these limit access to HIV testing and treatment services for those most at risk (UNAIDS 2016d, 16).

Specific actions to address the social and structural barriers are spelt out in Strategy2016: legislation, law enforcement and social programmes must be strengthened to end intimate partner violence (UNAIDS 2015c, 108); girls access to secondary school education increased; cash transfers used to provide economic empowerment for women, to enable them to stay in school and make healthy partner choices (UNAIDS 2015c, 70); legislation and other barriers that require a third party to authorize women and young people's access to sexual and reproductive health services must be removed; same sex relationships, cross-dressing, sex work and drug possession for personal consumption must be de-criminalized; and programmes to address stigma and discrimination in communities and healthcare settings must be scaled up (UNAIDS 2016d, 16).

Condoms are a central pillar of combination prevention programmes and in order to increase their availability to 20 billion by 2020, increased resources are needed for their procurement, promotion and distribution. Both male and female condoms are needed as well as lubricant. Communities must be included in new ways to change the perception of condoms amongst populations at risk and promote their use in the face of complacency (UNAIDS 2016d, 30). If voluntary male medical circumcision can be scaled up to 80 percent coverage, then it has been predicted through modelling studies that 3.4 million new HIV infections can be prevented by 2020. Following the initial announcement of its effectiveness, programmes scaled up rapidly, but then plateaued. More investment must be created at national level and programmes integrated into national health systems to reach more people. Social myths and misconceptions need to be addressed to pave the way for scale up both adult circumcision and to increase the numbers of adolescent and infant circumcisions (UNAIDS 2016d, 40).

People who inject drugs and share needles are at high risk of infection with HIV. There is now clear evidence that needle exchange to reduce the harm caused by injecting drug use is effective (Piot et al. 2015, 13). To achieve HIV prevention targets, harm reduction services must be scaled up for all people who inject drugs, including those in prison. People who inject drugs must also have access to ART. Laws must be reformed to ensure people who use drugs are not faced with punitive sanctions, but are enabled to access clean needles and opioid substitution therapy (UNAIDS 2016d, 44, United Nations 2016b).

Viral suppression through strong adherence to ART is a highly effective element of the combination HIV prevention approach. When large numbers of people living with HIV are able to access and stay on ART so that the amount of HIV virus in their body fluids is reduced to undetectable levels, then this prevents HIV infection among their sexual partners. The challenge is to get people to take up HIV testing, and access ART, when more than 14.5 million of the 36.7 million people living with HIV are estimated not to know their HIV status. Testing services including self-testing must be scaled up; community engagement in treatment and testing programmes must be increased, along with programmes to address the structural and legal barriers to accessing testing and treatment; WHO treatment guidelines should be implemented

so that clients are immediately offered ART following diagnosis; HIV treatment services must be scaled up, and combined with other prevention approaches (UNAIDS 2016d, 54).

Pre-exposure prophylaxis is the most recent addition to the combination prevention package. It is effective for people at high risk of HIV infection. This approach involves providing people at high risk of HIV infection with a single daily dose of oral ART (UNAIDS 2016a). This option is useful for people who need to control their own risk of HIV, when conventional HIV prevention approaches are problematic for some reason (UNAIDS 2016d, 20).

All of these approaches must be combined with efforts to encourage behaviour change and create demand. Community mobilization is needed for this range of actions to be successful, including changes in behaviour and in the social and cultural factors that continue to limit combination HIV prevention. Community service delivery mechanisms are needed to bring services closer to local communities and are particularly important in the delivery of rights-based approaches to HIV prevention among key populations, when services provided by the state may not be trusted by the community (UNAIDS 2016d, 26).

This is a very detailed and long list. It is however important to document carefully what combination prevention entails because there are significant areas of controversy and tension between the discourses around HIV prevention and some of these recommendations are omitted from or language weakened in the PDs as a result.

UNAIDS Strategic direction two: treatment care and support- the HIV treatment technical package

Scaling up ART provision saves the lives of people living with HIV; it is also a central part of HIV prevention. This thesis and framing section do not focus on treatment, as it is not a source of tension with the traditional religio-cultural discourse, rather treatment is a potential entry point for collaboration.

The first place to start, in scaling up access to ART for PLHIV is to increase HIV testing, so that people can know their HIV status. As with HIV prevention, testing must also reach the populations and locations where people are most at risk and numbers of new infections are the highest in order to be effective. Integrating HIV testing into settings where other medical tests are conducted is one approach. WHO recommends four actions countries can take to scale up HIV testing: Firstly, to diversify ways and places in which testing is provided, such as in health facilities, where other medical tests are being conducted, in community settings and through networks of key populations as well as to promote self-testing. Secondly, to focus testing services and scale up among populations and in locations where the burden is greatest. Thirdly, to expand testing for infants. Fourthly, to ensure that testing services are provided ethically and in line with human rights (WHO 2016b, 35).

HIV commonly occurs along with other infections such as tuberculosis and viral hepatitis. Mothers who have been infected with HIV may also have been infected with other sexually transmitted diseases such as syphilis, which can also be transmitted to their infants; efforts to treat HIV must therefore be integrated with treatment for these other co-infections. WHO suggests four actions for countries to take to scale up HIV treatment; first, to ensure national treatment guidelines are regularly updated and implemented in-line with WHO guidelines and protocols, including for co-infections; second, to develop and update plans to ensure treatment is continued and that guidelines are clearly defined for when to change medication regimens; third, to implement strategies to prevent HIV drug resistance; and fourth, to make the WHO package of care for chronic illnesses available to PLHIV, including community, home-based, palliative and end-of-life care (WHO 2016b, 37).

Development and debates within a public health discourse.

Public health approaches as described in the literature beyond HIV and as practiced in the field focuses on both individuals and populations. It extends beyond a concern for the health of an individual to consider the social context in which illness or disease is occurring. Biomedical and technical elements are included in public health but are not the sole focus of the response. There is an emphasis on prevention of illness among individuals and communities and the promotion of good health. Human behaviours and social factors that put people at risk of illness must be addressed for this approach to be successful. The disciplines of epidemiology, scientific research and medical practice are combined with other disciplines such as social science, anthropology and psychology. Research is both laboratory and field-based, where environmental factors, nutrition, migration and population movements and their impact on health are also studied. The balance between these elements differs between different disease areas and can have important effects on practice (Harvard 2017).

By contrast, a biomedical approach focuses on the individual; there is an emphasis on diagnosis, treatment, and care for the patient. Medical specialists provide expert advice, prescribe and monitor the treatment and the scientific research to support this approach is primarily laboratory and clinically based. The randomized controlled trial leading to quantitative analysis and clear results is seen as the gold standard for determining the best medical interventions. Social sciences feature much less in this approach and qualitative research is considered of less value (Harvard 2017).

Current leaders and authors in the wider field of public health include Margaret Chan, Director-General of the World Health Organization; Mark Dybul, former Executive Director of the Global Fund; Thomas Frieden, former Director of the US Centers for Disease Control; Richard Horton, Senior Editor of The Lancet; and Jim Kim, President of the World Bank. Some of their work reveals a nuanced but important difference in approach to public health than the framing seen in

the HIV strategies of WHO and UNAIDS. Jim Kim places his emphasis on the poor and addressing the economic impact of health on already impoverished families (Kim 2013). Frieden and Horton both place a much stronger emphasis on technical and biomedical approaches first and place community engagement as a secondary factor. In academic publications by these authors, communities are not positioned as leaders in the field, but as recipients of services, and partners to be educated so that their behaviours can be changed, and they can assist in the implementation of public health actions. Political leadership is highlighted as key to a successful public health response. Human rights and gender equality are not positioned as central priorities in public health in the same way as they are in the AIDS field (Frieden 2014, 2015, Horton 2016b, Frieden et al. 2014, Horton 2016a) (Horton et al. 2014).

The more narrowly biomedical approach to public health is clearly evident not only in the literature but also in practice in the way that the Ebola response was both framed and managed. I was seconded to WHO to support the Ebola response for nine months and travelled to Sierra Leone. It was clear during this epidemic that the dominance of a biomedical and technical approach to public health in this context was detrimental to the initial response and took precedence over community engagement and human rights considerations. WHO later brought in experts in community engagement, anthropology and social science when this imbalance became apparent, but the architecture of the Ebola response did not draw on learning from the AIDS response, and UNAIDS Secretariat representatives were not included in the joint teams established at country level once the United Nations Mission for Ebola Emergency Response (UNMEER) system was established (Marshall and Smith 2015, Eba 2014). This is one clear and current example of internal debates within the field of public health hindering an effective epidemic response.

Annex 4: Human rights, gender equality and community engagement

This annex contains additional information to support the discussion of human rights, gender equality and community engagement as a policy frame articulated in Chapter 4. It includes the strategic directions and actions included in Strategy2016 on Human rights, gender equality and community engagement and some additional discussion on the development and debates to augment basic information in Chapter 4.

Goals and targets; strategic directions and actions on human rights proposed by Strategy2016

The goals and targets of Strategy2016 have been outlined in Chapter 3 and annex 3. To achieve these goals and targets Strategy2016 sets out one result and four outcomes to be achieved under SDG (16) Peace, justice and strong institutions (UNAIDS 2015c, 11)

Result

- Punitive laws, policies, practices, stigma and discrimination that block effective responses to HIV are removed

Outcomes

- Punitive laws, policies and practices removed, including overly broad criminalization of HIV transmission, travel restrictions, mandatory testing and those that block key populations' access to services
- People living with, at risk of and affected by HIV know their rights and are able to access legal services and challenge violations of human rights
- HIV-related stigma and discrimination eliminated among service providers in health-care, workplace and educational settings
- Laws, policies and programmes to prevent and address violence against key populations issued and implemented

It also proposes seven core actions that countries can take to promote just, peaceful and inclusive societies (UNAIDS 2015c, 67):

- Remove punitive laws, policies and practices that violate human rights, increase people's vulnerability to and risk of acquiring HIV and impede utilization of services, including travel restrictions and those that block key populations' access to services.
- Eliminate discrimination and stigma against people living with, at risk of and affected by HIV, including in healthcare, workplace and educational settings, and equip service providers with the skills and tools to respect people's HIV-related rights.

- Expand programmes that enable people living with HIV, other key populations, women and girls and affected populations to know their rights, access justice and challenge violations of rights regardless of age, health status, gender, sexual orientation and gender identity, drug use, immigration status or involvement in sex work.
- Identify HIV-related legal and human rights obstacles and challenges in country plans and increase funding for and implementation of programmes supporting social, political and legal environments that enable people—especially key populations, including their young members—to access HIV services and safeguard human rights.
- Promote tolerance and protection against discrimination and violence, and ensure access to HIV services for all, including key populations.
- Fully monitor HIV-related violations of human rights, legal and policy barriers and discrimination, as well as people's experience of stigma (including self-stigma) by fully implementing such tools as the People Living with HIV Stigma Index.
- Forge partnerships and alliances to promote and defend human rights in the context of HIV, including with civil society, faith-based actors, law enforcement, executive branches, members of parliament, the judiciary, universities and the private sector.

Where the law has been used as a tool to manage the HIV response there is evidence of 'overly broad' use of criminal prosecution of sexual activity. Examples of this 'overly broad' application of the law are provided by the Global Commission on HIV and the Law (UNDP 2012, 22).[37] Evidence does not support the use of criminal law to control HIV infection, rather analysis of the available evidence indicates that decriminalization of sex work, injecting drug use and adult consensual same-sex relationships can reduce the risk of HIV and vulnerability to HIV infection (UNAIDS 2015c, 64).

Patrick Eba discusses the set of HIV-specific laws introduced across the 27 countries of sub-Saharan Africa, which were intended to address not only issues of HIV transmission, but also the provision HIV information and education and services, and to protect people living with HIV from violence and discrimination based on HIV status. He concludes that whilst there are serious concerns with these laws, they can be reformed and that reform should be based on the principles of 'smarter legislation' that include meaningful and participatory processes, public health and human rights principles (Eba 2016, 183).

[37] The main "criminal activity" for people who are HIV positive is sex, and the laws can be overly broad and the penalties draconian. For instance, Bermuda makes it a crime for people living with HIV to have any kind of sexual contact in which body fluids might pass to another person. As a consequence, two people have received ten-year sentences, though HIV was not transmitted in either case. In Singapore, those who merely have reason to believe that they may be HIV-positive or might have been exposed to significant risk of contracting the virus face ten years' imprisonment if convicted of having sex without informing their partner of the possible risk or taking reasonable precautions against transmission (UNDP 2012, 22).

When stigma and discrimination is deeply engrained in culture and society it also fuels stigma and discrimination in healthcare and other formal settings as the quotation below demonstrates (UNAIDS 2015c, 37).

> The *People Living with HIV Stigma Index* measures stigma and discrimination reported by people living with HIV. Stigma Index surveys have been conducted in more than 65 countries. In 22 of these countries, more than 10 percent of people living with HIV reported they had been denied healthcare, and more than 1 in 10 people living with HIV reported they had been refused employment or a work opportunity because of their HIV status in the 12 months before the survey. In 30 countries where surveys were conducted, 1 in 10 people living with HIV reported they had lost a job or another source of income because of their HIV status (UNAIDS 2016c, 10).

People living with HIV and key populations experience human rights violations and are often unable to access legal assistance; this is particularly a problem when misuse of criminal law leads to imprisonment of key populations. Prisons do not always provide adequate health services; mandatory HIV testing without appropriate counselling and confidentiality is common. Similar problems are faced by migrants, refugees and asylum seekers. Some of these violations are committed by state actors and all of these restrictions and violations increase people's vulnerability to, and consequences of HIV infection (UNAIDS 2015c, 37).

Goals and targets, strategic directions and actions on gender equality proposed by Strategy2016

The goals and targets of Strategy2016 have been outlined in full in section 3.2.1. To achieve these, Strategy2016 also sets out one result and five outcomes to be achieved under SDG 5 Gender equality.[38]

Result

- Women and men practice and promote healthy gender norms and work together to end gender-based, sexual and intimate partner violence to mitigate risk and impact of HIV

Outcomes

- Women and girls and men and boys engaged and empowered to prevent gender-based, sexual and intimate partner violence, and promote healthy gender norms and behaviour
- Laws, policies and practices enable women and girls to protect themselves from HIV and access HIV-related services, including by upholding their rights and autonomy
- Sexual and reproductive health and rights needs fully met to prevent HIV transmission

[38] The United Nations Millennium Development Goals (MDGs) included reference to "gender equality" in one of the eight targets to be achived by 2015.

- Young women in high-prevalence settings access economic empowerment initiatives
- Women meaningfully engaged in decision-making and implementation of the AIDS response

It also proposes seven core actions that countries can take to achieve gender equality and empower women and girls (UNAIDS 2015c, 63):

- Ensure laws, policies and practices uphold women's rights and autonomy; advance gender equality; meet the sexual and reproductive health and rights and HIV-related needs of women in all their diversity; and support access and adherence of women, young women and girls to prevention, treatment and care across their life cycle, especially those from the most vulnerable communities.
- Empower women and girls, including those living with HIV, to uphold equally their economic, legal, political and social and sexual and reproductive health and rights, as well as opportunities for participation, leadership and decision-making of their own.
- Ensure that country HIV responses address links with gender inequality and gender-based violence, such as provisions for survivors of sexual and gender-based violence, including in humanitarian emergencies.
- Scale up interventions to reduce gender-based violence as a cause and consequence of HIV infection and harmful practices, including forced marriage, forced sterilization and forced abortion.
- Transform unequal gender norms in the context of HIV, working with men and boys, women and girls, community, cultural and faith leaders and the private sector.
- Invest in organizations that advocate for gender equality, women's rights and empowerment, and build bridges between networks of women living with HIV, the women's movement and the AIDS movement, as well as with governments and international organizations, to assure women's participation in the governance of the HIV response.

The factors which put women and adolescent girls at increased risk of HIV infection are complex. These vulnerabilities play out in unequal power dynamics between men and women, which result in a complex set of sexual networking patterns, particularly in sub-Saharan Africa where the rates of HIV infection among young women are the highest. A recently published research study conducted by Tulio de Oliveira and colleagues in South Africa examined the sexual transmission networks by which these increased HIV infection rates among young women are perpetuated. This research suggests that:

> Men aged 25–40 years were the primary source of the high rates of HIV acquisition in adolescent girls and young women (15–25 years). Many of these men had acquired HIV infection from women aged 25–40 years, which is the group with the highest prevalence of HIV. Over time, when the current group of adolescent girls and young women reach their 30s, we expect that they will then constitute the next group of women with high

HIV prevalence, thereby perpetuating the cycle of HIV transmission to men in their 30s who will infect the next cohort of adolescent girls and young women (de Oliveira et al. 2017, e47).

This risk and vulnerability cycle is well illustrated by following graphic (UNAIDS 2016b, 36):

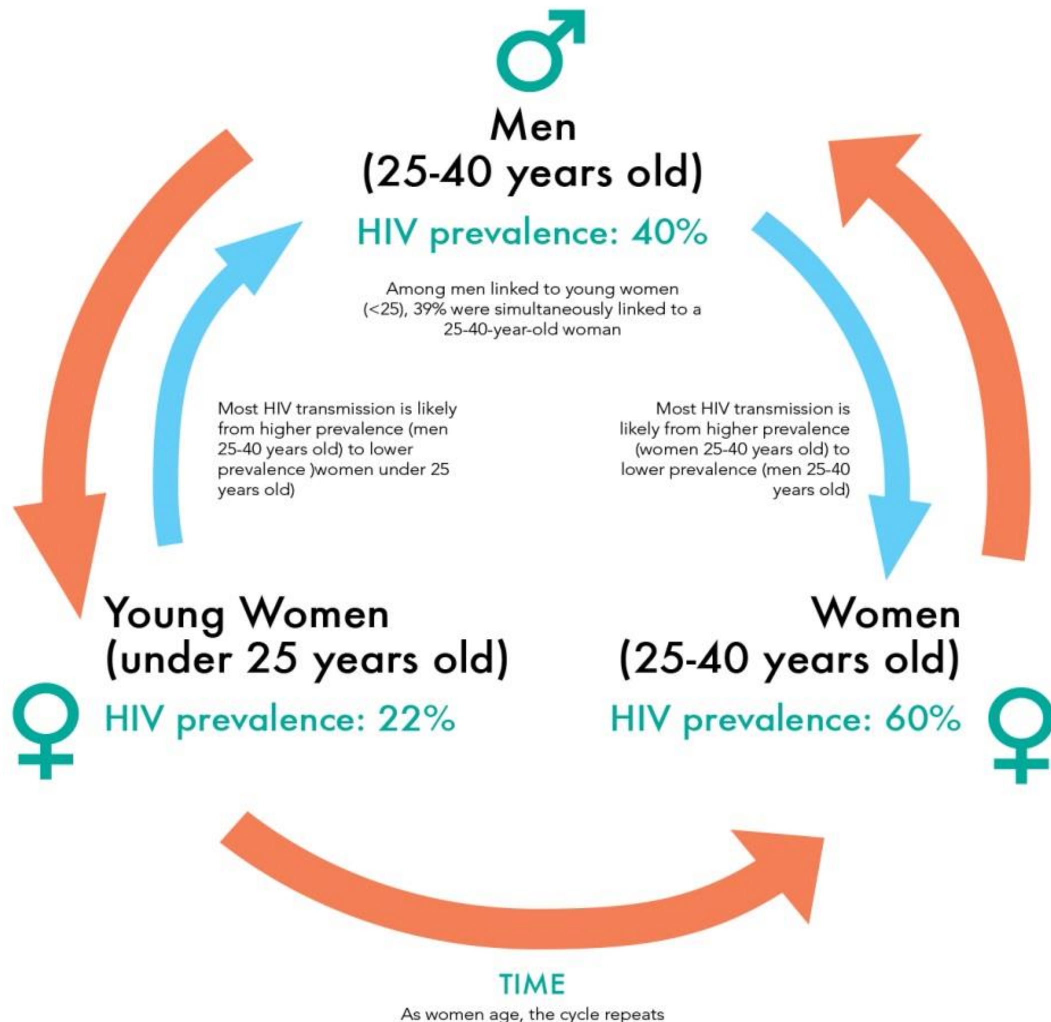


Figure 1: Cycle of HIV transmission, results from a phylogenetic study, Kwazulu-Natal, South Africa, 2016

For many years it was thought that young women were infected with HIV by men approximately ten years their senior. This issue was debated in the literature and various strategies were proposed to reduce their risk and vulnerability. The study by de Oliveira et al has produced a more nuanced picture, using a technique called phylogenetic analysis on blood samples to construct a 'likelyhood tree' of HIV infection newtorks. As shown in the graphic, there appears to be a triangluar set of relationships taking place. Interviews confirmed that men interviewed in this study were linked to women in both age groups, which confirms these findings (de Oliveira et al. 2017, e47) (see Annex 4.1)

The Secretary General's report '*On the fast track to ending the AIDS epidemic. Report of the Secretary-General',* released in April 2016 outlines these factors in much greater detail and also proposes a series of recommendations, which MS are urged to adopt to address the increased risk and vulnerability of women and girls to HIV infection (Secretary-General 2016, 75). WHO took these recommendations further in February 2017, issuing '*Consolidated guideline on sexual and reproductive health and rights of women living with HIV*' (WHO 2017) to support countries to implement these actions.

Development and Debates

Judith Butler is considered to be the founder of modern gender theory. Her publication *Gender trouble: Feminism and the subversion of identity* is cited as one of the first academic publications to articulate some of the questions and theoretical considerations underpinning a social movement among women and LGBT people in the 1980's (Butler 1990).

In her preface to the 1999 edition she acknowledges that the field has changed, that theory has changed along with cultural changes and that her own thinking has matured. She reiterates one of the questions that her original work *Gender trouble* sought to address:

> (T)he text asks, how do non-normative sexual practices call into question the stability of gender as a category of analysis? How do certain sexual practices compel the question: what is a woman, what is a man? If gender is no longer to be understood as consolidated through normative sexuality, then is there a crisis of gender that is specific to queer contexts? (Butler 1990, xi)

Two of Butler's initial questions were whether 'sexual practice has the power to destabilize gender' and whether that 'normative sexuality fortifies normative gender' (Butler 1990, xi). Drawing on the work of Foucault, Butler's original text challenged some of the dominant social and religious constructions of gender in ways that shook the power structures that maintain social control and the status quo. Some of the reactions to these challenges from supporters of a traditional religio-cultural discourse are discussed in chapter 5 and annex 5.

A framework document on what women want by the Athena network brings the discourse on women, girls and gender equality in the context of HIV and sexual and reproductive health and rights up to date. Young women of East and Southern Africa list their 'asks' of the international community (ATHENA 2016, 20):

- Comprehensive sexuality education and youth friendly services
- Clean and proper equipment in labour wards
- End human rights violations such as the forced and coerced sterilization of women living with HIV
- Access to education for girls

- HIV literacy – prevention literacy for girls and young women through school-based curricula and also through working with parents
- Advocacy messages that speak to the complexity of women's lives
- Bold governments that pass radical policies and place power in the hands of women. An end to lip service to women's and girls' empowerment
- Contraceptive options
- Awareness and education on available SRH and HIV services, tools and information in our communities
- Sensitization of healthcare providers and police to end stigma and discrimination
- Mentorship programs to support more young women leaders.

Both of these texts include the third central pillar of the discourse of human rights, gender equality and community engagement: which is meaningful participation by the communities most affected by the epidemic.

Community Engagement

Community engagement is a central element of the human rights, gender equality and community engagement discourse. UNAIDS and Stop AIDS Alliance identify four main areas where community responses are important to the success of the HIV response. These are expanded in annex 4.1. i) Advocacy, campaigning, participation and accountability, ii) Community-based service delivery iii) Community-based research and iv) Community-based financing (UNAIDS and Stop AIDS Alliance 2015, 3).

As funding shrinks due to the ongoing financial crisis however, there is a real danger that community responses will collapse at a moment in the HIV response when HIV services need to be scaled up rapidly. Collins et al call for a paradigm shift in the HIV response to engage communities more effectively:

> We must utilize the unique strengths of communities in creating resilient and sustainable systems for health. There are several priorities for immediate attention, including agreement on the need to nurture truly comprehensive systems for health that include public, private and community activities; re-examination of donor and national funding processes to ensure community is strategically included; improvement of data systems to capture the full spectrum of health services; and improved accountability frameworks for overall health systems. Health planning and financing approaches run by governments and donors should institutionalize consideration of how public, community and private health services can strategically contribute to meeting service needs and accomplishing public health targets (Collins et al. 2016, 1).

Additionally, civil society advocacy is important to hold governments accountable to providing adequate finances for the HIV response, ensuring that services are provided to populations most in need and that young people and other key populations can participate meaningfully in decision making.

Funding is shrinking, but at the same time political space for civil society activism and advocacy is shrinking. In this context work to advance human rights and gender equality is under threat. This is documented by Andrew Firmin, based on research undertaken with civil society networks across 22 countries many of whom report that governments are increasingly demanding reporting from NGOs and that their activities are conducted in line with national priorities. This is not a problem when the priorities of the NGO is in line with national priorities, but when their work challenges overly broad legislation, or highlights human rights abuses by the police or health-care staff then this limits the ability of civil society to act as an independent watchdog (UNAIDS 2015c, 37, Firmin 2017, 49).

Civil society, feminist and women's movements have tried to counter this prevailing discourse in many countries, but all too often conservative religious influences on funding curtail the activities of civil society groups and NGOs. There is increasing evidence of a narrowing of space for civil society advocacy and shrinking funds for this important work in both the gender and the HIV fields (UNAIDS 2015c, 37, Razavi and Jenichen 2010, 4)

Strategy2016 makes reference to community engagement and service delivery in two result areas and core action sets (UNAIDS 2015c, 10). These will be compared with the text finally included in the 2016 PD.

Result areas, community engagement

Good health and well-being (SDG 3)

- Accessibility, affordability and quality of HIV treatment improved, including through community delivery systems

People-centred HIV and health services are integrated in the context of stronger systems for health (SDG17)

- People living with, at risk of and affected by HIV empowered through HIV-sensitive national social protection programmes, including cash transfers
- People living with, at risk of and affected by HIV access integrated services, including for HIV, tuberculosis, sexual and reproductive health, maternal, newborn and child health, hepatitis, drug dependence, food and nutrition support and non-communicable diseases, especially at the community level
- Comprehensive systems for health strengthened through integration of community service delivery with formal health systems

The following are set out as core actions for the global response to ensure healthy lives and well-being for all at all ages (UNAIDS 2015c, 55):

Broaden options for targeted rights-based, evidence-informed and gender- and age specific HIV testing through expanded community-led counselling and testing, home testing and innovative public–private partnerships.

Strengthen and broaden the delivery of ART, viral load monitoring, adherence and other forms of care and support, such as income-generation programmes for people living with HIV, including by scaling up task-shifting and community-based service delivery, accelerating the adaptation of recommended regimens and revitalizing treatment literacy programmes, with particular focus on reaching underserved, higher-risk populations.

Core actions to reduce inequality in access to services and commodities (UNAIDS 2015c, 61):

- Expand financial support to strengthen and sustain innovative community-based programmes and the leadership and engagement of networks of people living with HIV, key populations and other populations disproportionately affected by inequality and HIV, including support to reinforce youth movements through mentoring and capacity-building activities.

Scaling up treatment will require countries to complement facility-based services with an array of non-facility-based approaches. Enabling efficient scale-up requires expanding community-based HIV service delivery from a global average of 5 percent in 2013 to cover at least 30 percent of all service delivery in 2030 (UNAIDS 2015c, 52).

Annex 5: Traditional religio-cultural discourse

This annex contains two sections of text to complement Chapter 5. The first augments the 'Development and Debates' discussion in section 5.4 and attempts to document from the perspective of its proponents, how the elements of the traditional religio-cultural discourse around sexual, reproductive health, family issues and HIV has developed. The second, augments the 'Supporters and Strategies discussion in section 5.5 providing additional examples of supporters of the traditional religio-cultural discourse at the UN and their strategies.

Development and debates

This section augments the discussion in Chapter 5 section 5.4 and attempts to document from the perspective of its proponents, how the elements of the traditional religio-cultural discourse around sexual, reproductive health, family issues and HIV has developed. The description is not exhaustive and draws on several different sources, it provides background to how the current constellation of issues and players, central to the traditional framing came together over time.

Development of the debate around women and girls

Jane Adolphe, Catholic Associate Professor of Law, (Adolphe 2012) provides a brief history of this debate from the perspective of a traditional religio-cultural discourse. She uses the word gender as a focus for her analysis, as this concept has served as a lightning rod, drawing out different perspectives of the debate. This section will briefly review the historical debate as explained by Adolphe. It references in addition other authors who highlight some important themes in the debate, which are evident in international policy documents including the PDs on HIV/AIDS.

Tensions around population control and SRH

In the 1960s, as concern around population size grew, and population control measures were discussed and proposed, including; to educate women on family planning, this touched raw nerves among newly independent MS keen to establish a strong nation, and religious actors; Christianity and Islam in particular. Concepts of population control remain contentious for some MS, for religious groups, and for the women's movement. This debate came to a head in Cairo in 1994 (Beattie 2014, 3, Weigel 1995).

From women as mothers and care givers to women in development

From 1963 to 1975 a key theme of the international debate was 'Women in Development', which marked a shift in focus from families to the importance of women's contribution to development. This shift was significant for the traditional religio-cultural discourse, as the

centrality of the family and women's role as mothers and care givers are key pillars of this discourse.

1975 was designated International Women's Year and the first World Conference on Women took place in Mexico. The General Assembly established 1976-85 as an International Decade for Women and mandated the drafting of the Convention on the Elimination of Discrimination Against Women (CEDAW) (Adolphe 2012, 8).

Equal rights for women

The UN Decade for Women: Equality, Development and Peace (1975 to 1985) was a period when the equal rights, opportunities and resources for development of both women and men were promoted. CEDAW was adopted by the General Assembly in 1979 and came into force in 1981. CEDAW prohibits discrimination on the basis of sex, citing the principle of equality between men and women, (General Assembly Resolution 1979, 1). States were called upon to take "legal measures to abolish existing laws, regulations, customs and practices which constitute discrimination against women" (General Assembly Resolution 1979, 2). The Holy See is not a signatory to CEDAW.

Violence against women

From 1986 to 1995 the focus of women's health discourse shifted to address violence against women; a landmark was the adoption of the Declaration of the Elimination of Violence Against Women in 1993 (General Assembly Resolution 1993).

Gender equality and empowerment of women

The International Conference on Population and Development (ICPD) took place in Cairo in 1994 (United Nations 1995b) and the Fourth Global Conference on Women took place in Beijing in 1995 (United Nations 1995a) (Adolphe 2012). Prior to and during these conferences, tensions between the traditional religio-cultural and the public health, biomedical, human rights and gender equality discourses were high. At Cairo those supportive of human rights, gender equality and community engagement, called for the inclusion of language on sexual, reproductive health and rights (SRHR). George Weigel outlines differences of opinion on the content of the draft declaration as well as the strategies used by different constituencies to achieve their goals (Weigel 1995, Beattie 2014). Proponents of the traditional discourse were critical of the draft document for its lack of reference to the centrality of marriage and attempts to introduce 'new rights', including 'reproductive rights'. Central to the conflict was abortion. Weigel notes that the Holy See and MS with majority Catholic or Islamic populations were active in the debate:

> the most consequential thing that the planners of the Cairo conference had failed to take into account was the moral power of Pope John Paul II. That the Cairo conference did not adopt, but in fact rejected, key aspects of its planners' agenda was the result of a variety of factors: nervousness in Latin America, resistance from Islamic societies, and resentment in certain African countries of what they saw as Western cultural imperialism. But the sine qua non of the defeat suffered by the international advocates of the sexual revolution was the public campaign of opposition to the Cairo draft document mounted throughout the summer of 1994 by John Paul II (Weigel 1995).

Adolphe describes the intensified debate around the term gender that took place the following year in Beijing. She summarizes interventions from Martha Lorena de Casco, the delegate for Honduras, who raised concerns that gender was a 'core concept' in the text and asked for further clarification of the term. This is of particular relevance, because it provides evidence of a representative from a MS putting forward concerns closely aligned to the position of the Holy See in an international conference on women, thereby contributing to the framing of the traiditional religio-cultural discourse from a state perspective.

De Casco subsequently wrote a response to this controversy (de Casco 1995) which outlines key elements of the traditional framing. She argues that the term and concept of gender was being used to introduce a series of ambigious terms such as 'safe motherhood', 'sexual rights', 'reproductive rights', 'maternal health', 'the right to confidentiality', 'safe sex', and 'women's rights'. These terms she considers a serious threat to 'life, the dignity of the human person and national sovereignty' (Adolphe 2012, 16). Here, clear linkages between the concepts of the right to life, dignity of the human person, women's rights and national sovereignty, which echo the teaching and language of the Catholic Church on these same issues, are articulated by a Member State from a country with majority Catholic population.

At this consultation sixty member states came together to agree on a working definition of gender, as the term was highly contested in the debates. They agreed to maintain the existing definition (United Nations 1995a, 218).

The period 1996-2006 saw a series of significant events. The Rome Statute of the International Criminal Court, which was established in 1996 and came into force in 2002, contains a legally binding definition of gender:

> For the purpose of this Statute, it is understood that the term "gender" refers to the two sexes, male and female, within the context of society. The term "gender" does not indicate any meaning different from the above (General Assembly Resolution 1998, 7.3).

This definition of gender is frequently referred to by proponents of the traditional discourse during international negotiations. Adolphe, documents some of the debate leading up to this

definition, attributing success in securing a definition of gender to lobbying from 'the Holy See, countries with large Catholic Populations and Arab States' (Adolphe 2012, 25).

The Holy See's statement at the 62nd Session of the UN GA to review progress on the MDGs provides a clear example of the traditional religio-cultural framing. It referes to the HIV epidemic, which serves to transition this chapter from the debates around women, girls and SRHR from the 1960s to 2000 to examine how these conflicts have spilt over into the HIV response.

> There has been slower progress in addressing maternal health, HIV/AIDS, malaria and tuberculosis. The overriding cause of the slow progress has been the lack of resources at the most basic levels of healthcare and the continued lack of access to even basic health services. It has long been demonstrated that investing in primary healthcare, rather than in selective, culturally divisive and ideologically driven forms of health services, which camoflage the destruction of life among medical and social services, is one of the most cost effective and successful ways to improve the overall quality of life and the stability of families and communities (Holy See 2008, 3).

Transfer of the debates to the HIV response

The global health commuity became increasingly concerned about HIV in the early 1980s. WHO convened the first meeting on HIV/AIDS in November 1983. At this early stage the report was framed entirely in biomedical terms. Whilst it noted that there were differences in how the diseases affected men and women there was no human rights, gender, or traditional religo-cultural framing in the text (WHO 1983).

Early references to HIV in the international documents on women and SRH emerging from Cairo and Beijing include language which primarily frames the epidemic in biomedical terms. HIV/AIDS is described, concerns are raised about its rapid spread, the seriousness of the disease and actions to address it are included in the report and Platform for Action (POA) from Beijing. Some language in these texts is reflective of the traditional religio-cultural discourse: i) with regard to HIV education, highlighting the important role of parents in providing education (United Nations 1995a, 281e); ii) to make the link between the risk of HIV infection and 'substance-influenced unprotected and irresponsible sexual behaviour' (United Nations 1995a, 108n); and iii) to highlight the importance of abstinence and responsible sexual behaviour (United Nations 1995a, 45).

In the POA from Cairo elements of the traditional framing also appear, and are applied to AIDS alongside other sexual and reproductive health issues.[39] Reservations expressed by Malaysia and Brunei Darussalam stress the importance of respecting parental rights in HIV eduction. The Holy See in its closing remarks re-affirms that the use of condoms for HIV prevention is unacceptable (United Nations 1995a, 160- 161). These references and statements demonstrate that, before the first General Assembly meeting on HIV and AIDS took place in 2001, the traditional religio-cultural framing was already being applied in international documents to the AIDS response, supported by both the Holy See and MS.

By the year 2000 the HIV epidemic was much more serious. The MDGs included a target on HIV and AIDS 6.A: 'Have halted by 2015 and begun to reverse the spread of HIV/AIDS' (General Assembly Resolution 2000, 6A). In 2000 the UN Security Council Adopted its first ever resolution on a disease: *Resolution 1308 on the Responsibility of the Security Council in the maintenance of International Peace and Security: HIV/AIDS and International Peace-keeping Operations* (Security Council Resolution 2000). This document is concerned with the risk posed by the HIV epidemic to international and regional security, and on the need to provide HIV prevention education to peace-keeping forces. Traditional framing was absent from the document.

In 2001 the General Assembly adopted the first *Declaration of Commitment on HIV/AIDS* (DOC), which presents the epidemic as an urgent crisis: 'Noting with profound concern that by the end of 2000, 36.1 million people worldwide were living with HIV/AIDS, 90 per cent in developing countries and 75 per cent in sub-Saharan Africa' (General Assembly Resolution 2001, 3). It is framed predominantly in biomedical terms, with a strong human rights focus. Whilst the report recognizes and re-affirms the Cairo and Beijing POAs, gender is only mentioned twice in the DOC. The traditional framing is clearly present throughout the document; the importance of abstinence, faithfulness, and responsible sexual behaviour is mentioned and there is a strong and recurring theme on the importance of families. Further analysis of the DOC is included in Chapter 8.

Supporters and Strategies

Roles played by the Popes

Within the Catholic Church the direct teaching of a Pope is powerful in shaping doctrine and in influencing certain MS. The Popes have not hesitated to speak directly to the issues of human

[39] Responsible sexual behaviour, including voluntary sexual abstinence, for the prevention of HIV infection should be promoted and included in education and information programmes. Condoms and drugs for the prevention and treatment of sexually transmitted diseases should be made widely available and affordable and should be included in all essential drug lists. Effective action should be taken to further control the quality of blood products and equipment decontamination (United Nations 1995b, 8.35).

rights, family and SRH to influence MS on these issues at critical times through their general audiences and at the invitation of the UN itself, as this section will demonstrate.

George Weigel points to a powerful ‘resistance movement’ mounted by Pope Paul II, through his public messages over the summer of 1994 in advance of Cairo. Weigel’s analysis demonstrates how, prior to Cairo, John Paul speaks to the controversial issues in the draft document under negotiation and clearly sets out the Catholic Church’s traditional religious framing of the issues.

> In these reflections, the Pope emphasized that the right to life is the basic human right, "written in human nature," and the foundation of any meaningful scheme of "human rights"; spoke of the family as the "primary cell" of society and as a "natural institution" with rights that any just state must respect; defined marriage "as a stable union of a man and a woman who are committed to the reciprocal gift of self and open to creating new life, [which] is not only a Christian value, but an original value of creation"; defended the equal human dignity of women, insisted that women must not be reduced to being objects of male pleasure, and argued that "perfection for woman is not to be like man, making herself masculine to the point of losing her specific qualities as a woman"; noted that sexuality has a "language of its own at the service of love and cannot be lived at the purely instinctual level"; argued that stable marriages were essential for the welfare of children; pointed out that the Church does not support an "ideology of fertility at all costs," but rather proposes a marital ethic in which the decision "whether or not to have a child" is not "motivated by selfishness or carelessness, but by a prudent, conscious generosity that weighs the possibilities and circumstances, and especially gives priority to the welfare of the unborn child"; rejected coercive or "authoritarian" family planning programs as a violation of the married couple’s basic human rights and argued that the foundations of justice in a state are undermined when it does not recognize the unborn child’s moral claim to protection; declared that discrimination against women in "workplace, culture, and politics" must be eliminated in the name of an "authentic emancipation" that does not "deprive woman herself of what is primarily or exclusively hers"; and argued that radical individualism is inhuman, as is a "sexuality apart from ethical references."(Weigel 1995).

Anne Stensvold explores the development of the traditional religio-cultural discourse put forward by the Catholic Church at the UN through papal speeches to the UN, by Paul VI in 1965, John Paul II in 1979 and 1995, Pope Benedict in 2008, and Pope Francis in 2015. Paul VI and John XXIII’s speeches at the UN focus on common ground in addressing poverty, calling for justice and freedom, and focusing on freedom of religion (Stensvold 2016b, 102).

The tone changes with John Paul’s second address in 1995, immediately after the Beijing conference (and a year after his series of general audiences summarized above by Weigel). He introduces the moral values discourse with language that firmly connects being born into a

‘nation’ with being born into a natural family, situating the family as the natural place for children to be born and raised with others in the father/motherland. This ties together the Catholic Church’s definition of the natural family, with the concept of this being ‘natural’ and thus not to be challenged, and with the concepts of nationhood and tradition (Stensvold 2016b, 103).

In 2008 Pope Benedict XVI’s speech focused on re-affirming the status of the Holy See at the UN, challenging secularism and calling for religious freedom. The pope stresses the connection between human rights and ‘natural law’:

> It is evident, though, that the rights recognized and expounded in the Declaration apply to everyone by virtue of the common origin of the person, who remains the high-point of God’s creative design for the world and for history. They are based on the natural law inscribed on human hearts and present in different cultures and civilizations (Stensvold 2016b, 103).

Stensvold explains the significance of this quotation from Pope Benedict:

> Without a basis in natural law the human rights lose their claim to universality and become relative, the pope warns. In this, which I would call an act of appropriation, two things are achieved: the Church’s ethical hegemony is strengthened and the UN Declaration of Human Rights is redefined as anchored in the same authority (God) as the Catholic tradition (Stensvold 2016b, 103).

Pope Francis’s approach to the UN is light and friendly, making no reference to the status of the Holy See at the UN and he speaks in his own name. He focuses on the common challenge as a spiritual leader to address climate change, and the need for this to be grounded in moral law. Once again the pope makes the link between the natural law and the priorities of the UN. Even in the context of climate change he reaffirms the Catholic Church’s teaching on natural law and sexual relations:

> The defense of the environment and the fight against exclusion demand that we recognize a moral law written into human nature itself, one which includes the natural difference between man and woman (Pope Francis 2015a, 14b/3).

Roles played by Member States

Continuing the quotation by Brunai Darussalam in section 5.5.2

> We request that the following reservations and clarifications, which were made during our intervention at the plenary, be recorded and appended to the Platform for Action:

> (a) We wish to reiterate our stand on the sovereign rights of nations to implement the Platform for Action within the laws and practices and the moral and spiritual values of our country. (b) The interpretation of the terms family, individuals and couples refers to the traditional family formed out of a marriage or a registered union between a man and a woman and comprising children and extended family. (c) We are of the conviction that reproductive rights should be applicable only to married couples formed of the union between a man and a woman. (d) We wish to state that the adoption of paragraph 96 does not signify endorsement by the Government of Brunei Darussalam of sexual promiscuity, any form of sexual perversion or sexual behaviour that is synonymous with homosexuality and lesbianism. (e) In the context of paragraph 106 (k) we wish to support the view that attention should be given to the prevention of unsafe abortions and the provision of humane management of complications of abortions as part of reproductive healthcare. However, abortion is not legal or permissible in Brunei Darussalam and can be performed only on medical grounds. (f) In the context of paragraph 108 (k), while agreeing that adolescent health is an area requiring attention due to the increasing problems of unwanted teenage pregnancies, unsafe abortions, sexually transmitted diseases and HIV/AIDS, we believe that parental guidance should not be abdicated and that sexual permissiveness and unhealthy sexual and reproductive practices by adolescents should not be condoned.

The following countries mention one or more of the elements of traditional framing in their reservations. Dominican Republic (right to life from conception; reservations of any terms that include abortion); Egypt, (marriage; family, national sovereignty, moral and religious values, inheritance rights, Sharia law; the national Constitution); Guatemala, (national soverignty; respect for the diverse religious, ethical and cultural values; the right to life from the moment of conception; unconditional respect for the right of parents to choose the upbringing of their children; interprets the concept of gender solely as female and male gender with reference to women and men) (United Nations 1995a, 154-175).

Other religious groups supporting a traditional religio-cultural framing at the UN

Christian Moe et al, describe in detail the same history as articulated by Adolphe, but from a standpoint openly critical of the traditional religio-cultural discourse, its supporters and the strategies used to put forward this discourse in international policy on HIV and SRHR and conclude:

> Since then, conservative religious actors have not only been able to set the agenda and define the terms for how certain discussions on the family are framed, but to a large extent have taken ownership of the very definition and concept of family (Moe, Stensvold, and Vik. 2014, 1).

Supporters of the traditional religio-cultural discourse include a very diverse group of faith partners and member states. A number of authors document the engagement of American evangelicals, The Church of the Latter Day Saints (Mormons), the Russian Orthodox Church, Family Watch International and member states with predominantly Islamic and Christian populations.

The success of this lobby is in part due to their ability to forge strong partnerships across a very diverse set of actors who hold a wide variation of beliefs on the details of the framing. The lobby has built consensus around a few broad issues which are strong enough, and emotive enough, to have gained powerful support and cement perhaps unexpected and sustained alliances between quite different religious and political groups. Through very skilful framing of the issues, by building strategic partnerships and forging strong linkages with the national sovereignty discourse, the coalition of lobbyists behind the traditional discourse have been very successful in embedding key elements of this discourse in the thinking of MS through their re-interpretation of official policy documents of the UN; documents which provide the foundation for evidence, rights and gender equality framing (Vik, Stensvold, and Moe 2013).

Supporters of the traditional religio-cultural discourse use several strategies to advance this discourse. They build partnerships with supportive MS. They frame the issues for them in language that resonates with religious and rights-based approaches. They identify and exploit fears and concerns among MS that their sovereignty is being compromised. They block text that does not align with the traditional religio-cultural discourse, and provide MS with 'alternative wording' to what are seen as controversial words and phrases (Vik, Stensvold, and Moe 2013, Family Watch International 2011). Negotiations become highly charged when supporters of the traditional discourse accuse MS and technical partners who put forward different interpretations of the same basic and undisputed rights as importing a 'culture of death', which lacks morals and destroys marriage and society (Moe, Stensvold, and Vik. 2014).

Position of the Russian Orthodox Church (ROC)

At this point it is worth noting the similarities between teaching of the Catholic Church and that of the Russian Orthodox Church (ROC) on the issue of dignity and human rights. The ROC does not have a privileged position at the UN in the same way as the Holy See, but as Vebjorn Horsfjord describes, it finds active support for its position through the representatives of the Russian Ministry of Foreign Affairs, particularly at the Human Rights council (Horsfjord 2016, 63).

In a document entitled: *Basic Teaching on Human Dignity, Freedom and Rights (BT) (Russian Orthodox Church 2010)* the two central concepts of dignity and freedom are given theological content (Horsfjord 2016, 65). As in Catholic teaching, the ROC's theological understanding of dignity is that it derives from people being created in the image of God. The ambiguity in the teaching of the ROC however, is that it appears that this dignity can be lost.

> At some points in the *Basic Teaching* the position seems to be that 'a morally undignified life' can overshadow, but not take away a person's inherent dignity and morality. But the text also states that 'according to Orthodox tradition, a human being preserves his God-given dignity and grows in it only if he lives in accordance with moral norms…. Thus there is a direct link between human dignity and morality (Russian Orthodox Church 2010, I.5) (Horsfjord 2016, 66).

Since human rights are afforded in recognition of basic human dignity, the question of whether dignity and hence human rights can be lost is critical. Within the teaching of the ROC there are two types of freedom: freedom of choice and freedom from sin (Horsfjord 2016, 66):

> While recognizing the value of freedom of choice, the Church affirms that this freedom will inevitably disappear if the choice is made in favour of evil. Evil and freedom are incompatible (Russian Orthodox Church 2010, II.2)

Horsfjord lists the evils assigned by the church: abortion; suicide; lechery, perversion; destruction of the family; the worship of cruelty and violence (Russian Orthodox Church 2010, II.2). The next steps in the ROC's theological argument link human rights to patriotism, patriotism to divine command, and rights to responsibilities towards the state and the community.

> Human rights should not contradict love for one's homeland and neighbours. The Creator has laid down in human nature the need for communication and unity, saying, 'It is not good for the man to be alone' (Gen. 2:18). The love of a person for his family and other loved ones cannot but spread to his people and the country in which he lives. It is not accidental that the Orthodox tradition traces patriotism back to the words of Christ the Saviour Himself: 'Greater love has no one than this, that he lay down his life for his friends' (Jn. 15:13). (Russian Orthodox Church 2010, III.4)

The ROC teaches that there is a balance to be drawn between individual rights and those of the community (Horsfjord 2016, 66). The combined result of this set of theological teachings is that a person's dignity, and therefore their human rights and liberty are linked to their making good moral decisions in line with church teaching, and being patriotic, behaving in ways that are supportive of the community. Failure to follow these teachings may lead to loss of dignity, rights and liberty. The implications of this combination of religious teachings for key populations at increased risk of HIV infection could be stark.

The Catholic Church and the ROC interpret human rights in line with a traditional religio-cultural discourse on issues such as: the dignity of the individual; human rights; freedom; the fundamental right to life; the centrality of marriage between a man and a women; families;

women’s role as mothers and care-givers; and the importance of national sovereignty. These are well established in international agreements and historically associated with one another. This association between the cluster of human and family rights and national sovereignty also becomes important over time.

With the addition of the early texts on the unaccepability of trafficking and prostitution listed in section 5.2.1 (General Assembly Resolution 1950) the elements and concepts associated with a traditional religio-cultural discourse and framing are established. At the time they were adopted these issues were not as contentious as they are today.

At the core of this traditional religio-cultural discourse are human rights and principles which are also held as critically important by the public health, biomedical, human rights and gender equality discourse supporters. There is genuine consensus between the different framings on issues such as respect for core human rights, the dignity and value of human life, and freedom from violence. The traditional religio-cultural discourse supporters however, have presented their interpretation of these core rights and principles as the only way to consider these foundational issues: as the ‘natural order’; a ‘given’ around which there can be no debate because it is a ‘self-evident fact’, as an approach that honours the ‘dignity’ of women, parents, children and respects their fundamental rights (Moe, Stensvold, and Vik. 2014, UNFPA 2016).

Annex 6: Political Discourses at the UN

This annex provides additional information and argument to support section 6.4, which answers the question, 'How do secularization and secularism influence political and religious discourses and policy-making on HIV and SRHR at the UN?'

Development and debates

The influence of secularization and secularism on political and religious discourses and policy-making on HIV and SRHR at the UN

This discussion is continued from section 6.4.1.

Secularism does not mean that religion has ceased to exist, or ceased to be relevant (Marshall 2017a, Olivier et al. 2006). Razavi and Jenichen challenge the notion that religion was ever absent from public life. They contend that even where there is a formal separation of faith and state in Western Europe, the domains of women, reproduction, families and welfare that have historically been the realm of religion and strongly influenced by the church, which has shaped national legislation in these areas. This has implications today for women, girls, HIV and SRHR (Razavi and Jenichen 2010, 2).

Desecularization theory and the 'apparent re-emergence' of religion into public life in different contexts are discussed by Jill Olivier, who comments that, since the late twentieth century, religion has become a valid topic for discussion again (Olivier 2010, 41). Azza Karam takes this up:

> To seek to increase the recognition of the value of religion in public life is critical and necessary in an international development culture characterized by a hegemonic secular Western ethos. This ethos has increasingly come under attack, and its upholders, invariably women's rights and human rights actors, are struggling at best in many non-Western countries to at least find a common ground between faith and rights (Karam 2016, 375).

Interaction between religion and state at national level relevant to HIV and SRHR.

This discussion is continued from section 6.4.2

Religion and nationalism

Razavi and Jenichen provide an overview of religion and nationalism in a special issue of *Third World Quarterly*, which contains a rich set of papers examining the intersection of faith and state in different contexts with reference to women, girls and SRH. This section discusses some

of the different types of interaction between state and religion at national level and the impact on women and girls arising from their review. In many countries, when the nation state was formed, religion was involved in its establishment in various ways. This means that later on, religious institutions can draw down on the investments they made at an earlier stage in the nation's history and negotiate for influence in certain areas of national life (Razavi and Jenichen 2010, 1).

Razavi and Jenichen explore the interaction of religion and nationalism in the post-colonial and post-communist era. These dynamics are relevant to this thesis for several reasons. First, some of the post-colonial countries are particularly sensitive to human rights, gender equality and sexual and reproductive health and rights at the UN, as they see these issues as Western imposition on their sovereignty. Second, in the process of states becoming independent, the interactions of faith and state can lead to a strengthening of ties between a conservative religious position on SRH and the state. This is described in the following section.

Under what is perceived to be an oppressive regime, nationalism can foster antagonism against the 'other' and increase ethnic hatred and violence. Religion can be invoked in these circumstances to reinforce the 'othering' of different ethnic or religious groups. Religion can be a powerful ally to a national resistance movement, influencing the way people vote if elections are involved. At the same time can use its support of the resistance movement towards change to negotiate for a greater role in the newly established state (Razavi and Jenichen 2010, 5). All these dynamics are of particular importance not only for women's equality, sexual and reproductive health and rights, but also for key populations at increased risk of HIV infection, who become the target of hate crimes. Social stigma and violence can increase vulnerability to HIV infection and decrease access to services (see chapter 4).

The complexities of who is using whom in these situations are often difficult to unravel, and the rights of women and the marginalized can be overlooked in times of rapid revolutionary change, especially those complicated by religious undercurrents. In national upheavals, women are often seen as 'bearers of the collective' and bearers of culture, responsible for producing and raising children, whilst men are generally assigned roles of re-defining and leading government of the new nation. Feminist attempts to challenge gender norms can constitute a threat to the new nationalism and provide religion with an opportunity to re-assert traditional views on marriage, gender roles and family life. Examples from Serbia and India in the special edition illustrate these dynamics (Razavi and Jenichen 2010, 5). Such national movements can serve to strengthen national religious identity following a shake-up, especially if religious groups have not been aligned with the previous ruling regime and are seen as an integral part of the struggle for liberation. In these circumstances, religion can take on a much greater role in the newly formed state, to the extent that in some countries it is then used to support or bolster a new regime, which in time can become oppressive. Razavi and Jenichen quote from the paper by Lisa Hajjar on Iran and Pakistan to illustrate this point.

> In both countries the state defines itself as Islamic, and conservative readings of Shari'a inform the legal domain. As Lisa Hajjar observes, where religious law becomes the law of the land, and where state power is exercised in the name of religion, 'defense of religion can be conflated with defense of the state, and critiques or challenges can be regarded and treated as heresy and apostasy'. Authoritarianism is thereby bolstered (Razavi and Jenichen 2010, 7).

These authors note that different religious traditions operate in similar ways in these struggles. The results for women are also similar; their sexual and reproductive roles are ultimately controlled by both state and religious (usually male) authorities. Even when feminist movements have been a part of the resistance struggle, their demands for equality are rarely realized in the new regime, which characteristically focus on the preservation of more conservative constructions of family, gender and sexuality (Razavi and Jenichen 2010, 8).

Razavi and Jenichen emphasise the importance of building effective partnerships between feminists working within and outside religious traditions. As highlighted in chapter 4, civil society engagement and partnerships are essential to the HIV response. Sexual and reproductive health and rights advocates, particularly women (and key populations) have much to lose when religion and politics are intertwined at national level. In some cultures, a rights agenda pits activists calling for reform against nationalists seeking to resist the imposition of alien 'Western' values on their culture (Razavi and Jenichen 2010, 11). In some countries, feminist religious scholars have been able to push the boundaries of public discourse and make way for reform. These activities can be effective when collaboration is forged between activists within and outside religious traditions and across countries. Activists working in constrained environments can work remotely with those in other countries, who may have more political and religious freedom to put the case forward.

From my experience, working in partnership with religious actors traditionally considered highly conservative is an important way to build bridges and working relationships on issues of common concern. These partnerships can help to depolarize ideologically constructed caricatures of one another and potentially open up the way for new thinking and a shifting of prejudices on both sides.

Types of interaction between faith and state visible at the UN

Debates cluster around four areas: Firstly, peace; some religious groups have long-term and very specific expertise in peace-building. For example, the community of St. Egidio advise or take part in peace negotiations or reconciliation by UN partners. These contributions are generally viewed positively (Marshall 2017a, 23). Secondly, around humanitarian emergency support and

relief, many religious NGOs (e.g., Islamic Relief) have longstanding presence in communities doing development work as well as specific engagement in relief and development activities in partnership with The United Nations Office for the Coordination of Humanitarian Affairs (OCHA) and United Nations High Commission for Refugees (UNHCR). These activities are also generally viewed positively (Marshall 2017a, 23). Thirdly, the protection of religious freedom and religious minorities is an area for religious activism and engagement. Some activists argue that freedom of religion includes freedom from blasphemy. This has become a contentious issue at the Human Rights Council (HRC) and is discussed in chapter 5 and annex 5. Fourthly, SRHR and HIV, including the definition of marriage, family and key populations at risk of HIV infection, have become the focus of strident activism since the mid-1990s. Activism on these highly contentious issues took on a more interventionist tone during the preparations for the Cairo and Beijing International Conferences (see chapter 5, annex 5) (Stensvold 2016a, 1, Marshall 2017a, 24).

More generally, since the contentious discussions at the 1994 Cairo Conference on Population and Development, religious groups, led by an improbable alliance between the Catholic Church and various Muslim-majority states, have lobbied actively within the UN to restrict the language of various declarations and agendas of meetings. These 'family values' advocates regularly seek to strip from documents any mention of the status of women, but even more so LGBTQ rights, gay marriage, abortion, and even many forms of family planning. This has serious implications both as it colours the image of religious groups beyond the topics at issue and because it contributes to the dilution of commitment to universal human rights (Marshall 2017a, 24).

Supporters and Strategies

Case study 1. The Russian Orthodox Church (ROC) and Russian Federation

The purpose of this example is to discuss the relationship between the ROC and the Russian Federation at the UN to demonstrate how a religious group and a MS intentionally work closely together to achieve their respective objectives.

Vebjorn Horsfjord argues that the ROC has a fear of secularism and its erosive effect on morality, and the Russian Federation is keen to challenge the current Western grip on global politics. Political and religious interests are therefore aligned (Horsfjord 2016, 63). Horsfjord explains that the Russian Ministry of Foreign Affairs and ROC have a working relationship, such that the permanent representative to the UN of Russia facilitated a speaking role for Metropolitan Kirill at the HRC (UNHRC) in 2008 (Kirill went on to become Patriarch of Moscow and all Russia i.e. the global leader of the ROC) (Horsfjord 2016, 62).

Kirill laid the foundation for 'traditional values' in his speech at the UNHRC in 2008, outlining four key elements of ROC's position on human rights: firstly, that 'there should be an alternative understanding of human nature'; secondly, 'that current human rights norms originate in and are

promoted by secular groups that in the global perspective are minorities'; thirdly, that 'different cultures may have different value systems that are not necessarily reflected in the human rights'; and fourthly, that 'some such cultures may be identified with specific nation states'. Thus, he obliquely identified the close relationship between the ROC and the Russian Ministry of Foreign Affairs (Horsfjord 2016, 62). The elements of the ROC teaching on human dignity and human rights are outlined in Chapter 5, annex 5.

Whilst Kirill did not explicitly mention 'traditional values' in his speech, it appeared soon afterwards in a UN document after the Russian Federation put forward a draft resolution at the UNHRC in 2009 entitled: 'Promoting Human Rights and Fundamental Freedoms Through a Better Understanding of Traditional Values of Humankind (A/HRC/RES/12/21)'. There were a series of follow-up workshops and resolutions in 2010 and 2012. One of the follow-up workshops was funded by the Russian Federation and leaders of the ROC were significant partners in the meeting. The ROC's purpose was to enshrine their theological interpretation of the linkages between human dignity, human rights, and the responsibility to make life choices in line with the teachings of the church, in a formal resolution of the HRC. The attempt failed, because in order to align the political and theological concepts of 'traditional values' in such a way that they could be presented in the UNHRC, the final concept was too vague to be argued through to a meaningful conclusion (Horsfjord 2016).

Whilst the term 'traditional values' has not appeared since in the title of any UN document, it is still part of a lively debate. What this case study seeks to demonstrate is the way that the ROC and the Russian Federation worked in tandem to first articulate the theological principles, then present them in a format that could be discussed in a UN setting. The church articulated the principles and the state opened the door to the church to influence the discussions, where it was in the interests of both parties to pursue this together (Horsfjord 2016). This is an example of an intentional partnership between a state and the ROC: if their attempt to secure a resolution at the HRC had been successful, then it could have led to a significant appropriation of the human rights agenda to the traditional religio-cultural interpretation of human rights.

Case Study 2. Organization of Islamic Conference (OIC) and the defamation of religion

This case study describes a similar collaboration, this time between MS working together under a common religious umbrella to champion the religious cause of defamation of religion at the UN. With 57 members, the OIC is the second largest intergovernmental organization in the world and is the only intergovernmental organization whose membership is based on religion. It speaks as the 'collective voice of the Muslim world' at the UN (í Skorini and Petersen 2016, 45). Unlike the Holy See, the OIC does not have preferential status at the UN, rather 57 MS put forward its views. With 57 members, achieving consensus is a challenge. OIC members share broad agreement on issues relating to gender and sexuality however (í Skorini and Petersen 2016, 46).

Hein I Skorini and Marie Juul Petersen discuss the ten-year struggle of the OIC to protect religion from defamation. Each year from 1999 to 2010, the OIC put forward a resolution on the Defamation of Religion. The OIC's presentation in Vienna in 1993 put forward Sharia law as an alternative framework to the secular human rights framework, which it argued was applicable to all countries. (Note here a similar strategy to the Holy See's claim that 'natural law' is applicable to all). At the time, individual states within the OIC were being criticised for discriminatory legislation towards non-Muslims or strong blasphemy laws in reports from the Special Rapporteur on Human Rights and by other MS in the HRC. These criticisms were received by these MS as attacks on Islam (í Skorini and Petersen 2016, 48).

The OIC discourse shifted over time. Initially, it demanded an alternative set of rights based on a religious framework, as articulated in the Cairo Declaration on Human Rights and Islam (The Organization of the Islamic Conference 1990). Between 1999-2010, the OIC presented its case in language resonant of, and in line with human rights language, locating defamation of religion within the universality of human rights and removing references to Islamic law and doctrine. It is important to note that these resolutions calling for protection of religion from defamation did not protect individuals from religious persecution. They were intended to protect a religion from the action or words of individuals or groups: 'As such the OIC's campaign in the UN is not about rejecting universal rights on the basis of cultural relativism, but about redefining the content of these universal rights'(í Skorini and Petersen 2016, 55).

There was much opposition to the language of this proposition by the OIC in the HRC and the resolution was amended significantly through the negotiations. The resolution finally adopted in 2011 was entitled: *Combating intolerance, negative stereotyping and stigmatization of, and discrimination, incitement to violence and violence against, persons based on religion or belief*. This is not what the OIC had campaigned for at all. The final resolution retains the original intent of UDHR, to protect the rights of the individual.

If it had been successful, this initiative could have altered the interpretation of human rights on freedom of religion. If states were able to define legislation on defamation of religion, it would have serious implications for religious minorities. If defamation of religion were to be extended to sexual minorities, this would have implications for SRHR and the HIV response. Though focused on the defamation of religion, this case contains lessons for the HIV response. It demonstrates the level of resistance among MS to individual agency when agency is appropriated in ways that transgress religious norms. There is a powerful movement among MS, which crosses religious traditions, to protect and promote the community and religious norms over and against individual rights. This is particularly applicable in the field of gender, SRHR and HIV, which appears to be where much of the consensus lies.

Annex 7: The broader religious discourse on HIV and AIDS

This annex should be read in conjunction with chapter 7 and provides examples of how the conceptual frameworks articulated in section 7.4 appear in public discourse on AIDS.

Development and debates

Advocacy and political activism (speaking to the world)

In 2000, the WCC launched the EAA, 'an international network of churches and church related organizations', to campaign on issues of common concern. EAA membership is broader than WCC membership. Catholics and Evangelicals are members of EAA and have been active partners in this advocacy work. HIV and AIDS was and remains one of the issues for global advocacy (Kurian 2016, 113). UNAIDS has worked in partnership with EAA since 2000. This review considers advocacy activities since 2011, since they were influential in leading and shaping the development and dissemination of the broad religious discourse.

In 2010 EAA, in partnership with UNAIDS, UNFPA and the Dutch Ministry of Foreign Affairs hosted a High Level Religious Leaders Summit in the Netherlands. The Summit explored opportunities for religious leaders to speak out, take action on HIV, and eliminate stigma and discrimination against people living with HIV. Religious leaders spent two days with PLHIV and experts from other sectors of the AIDS response. Over 60 participants attended the Summit, including participants representing Baha'í, Buddhist, Christian, Hindu, Jewish, Muslim and Sikh faiths, as well as high level representation from UNAIDS and UNFPA, the Dutch and Swedish AIDS Ambassadors, representatives of other organizations active in the response to HIV, and PLHIV (Ecumenical Advocacy Alliance 2010).

Participants signed a personal commitment to action. Subsequently, it was signed by over 400 religious leaders (EAA 2010).This statement includes key elements of the broad religious discourse on HIV: promoting human rights; addressing stigma and discrimination in faith communities; promoting meaningful engagement, facilitating leadership and full inclusion of PLHIV in faith communities; respecting, listening to and empowering PLHIV; challenging oppressive systems of power within religious communities; protecting women and children from violence; advocating for HIV prevention, treatment, care and support services for all; breaking the silence on HIV; challenging national governments to keep their commitments to HIV by providing services; holding governments accountable; maintaining personal accountability to this promise; and working across the faiths.

Following the Summit, UNAIDS partnered with EAA, INERELA+ and GNP+ to develop the Framework for Dialogue, a methodology to support structured dialogue at national level between networks of people living with HIV and religious leaders to address stigma and discrimination

(Ecumenical Advocacy Alliance 2011). The methodology starts with a presentation of the results of the national stigma index research conducted and presented by networks of PLHIV. This provides a powerful message to religious leaders that, despite their good works to address HIV, people living with HIV within their own country and churches face stigma and discrimination on a daily basis (Burton 2016, 24). The Framework for Dialogue has been an important tool in helping to make religious leaders much more aware of the lived realities of PLHIV; this is powerful in generating change and prompting leaders to re-visit their previously held theological views and interpretations of scripture. The publications of the WCC, including *Dignity, Freedom and Grace* (published to support the Framework for dialogue methodology), are critical tools to help leaders develop more open and theologically reflective approaches to HIV (Paterson and Long 2016).

In 2015-2016, prior to the UNGA HLM on AIDS, EAA, UNAIDS and partners worked extensively to prepare for the HLM through this network of churches, church-related organizations and religious leaders. This was in order to encourage advocacy with national political leaders to support strong language in the Political Declaration on HIV and AIDS, on human rights, gender equality, evidence-based approaches to HIV prevention and treatment, the eradication of stigma and discrimination, action to address gender-based violence, support the sexual and reproductive health and rights of women and young people, and to promote comprehensive sexuality education. EAA issued a call to action through their networks, which was launched by Rev. Phumzile Mabizela as part of her advocacy work on HIV in her role as Executive Director of INERELA+. The call to action and talking points were developed for church-based leaders and activists at national level to use in advocacy with their political leaders on HIV (Ecumenical Advocacy Alliance 2016a).

These documents take the broader religious discourse further than the religious leaders' personal commitment of 2010. They contain these additional commitments: to support funding for community and faith-based organizations to provide HIV services; to address stigma and discrimination towards marginalized and key populations; to defend human rights, and remove discriminatory laws and policies, particularly overly broad criminal laws that are a barrier to public health approaches and which block access to services for marginalized and key populations and violate human rights; to provide services safely in areas where such laws and policies are still in place; to address barriers to gender inequality (WCC-EAA 2016).

EAA also made similar statements at the Human Rights Council session on AIDS, and at the UNAIDS Programme Coordinating Board Meeting in advance of the High Level Meeting to promote and support the broader religious discourse and approaches supportive of human rights, gender equality and evidence-based HIV services among a broader set of partners (Ecumenical Advocacy Alliance 2016b).

EAA, Caritas Internationalis (CI), the Anglican Communion, and UNAIDS held a missions briefing in May 2016 when the negotiations process was underway. There was significant tension around

some of the language in the PD on SRH, RR, key populations, and comprehensive sexuality education for young people. The purpose of the briefing was to provide analysis and approaches from the perspective of a broader religious discourse to the MS representatives to bring some alternative perspectives to the negotiations.

Another thread of the advocacy in early 2016, in preparation for the HLM on AIDS, was with Caritas Internationalis, the Vatican, EAA, the Anglican Communion and other partners on scaling up access to paediatric HIV treatment for infants and children. This involvement with CI and the Vatican on HIV is critical to the broad religious discourse because the work of the Catholic Church on HIV is much broader than the narrow ideological positions put forward at the UN in negotiations. UNAIDS has a memorandum of understanding with CI and has worked together on a series of activities and publications to document elements this broader religious discourse on HIV present within Catholic Church responses.

Faith: part of the problem and a part of the solution

Kurian reflects on the dichotomy between churches providing much care and support to PLHIV, whilst also perpetuating stigma and discrimination. He suggests is an echo of the 'AIDS is a punishment from God' discourse, which sometimes contributes to ongoing and entrenched community perceptions that HIV does not occur among 'us', only among 'them'. In this way faith communities create distance between themselves and people living with HIV (Kurian 2016, 26). This is consistent with findings from a survey conducted by Simone Monteiro in Brazil, among women newly diagnosed with HIV. Monteiro states: 'In the case of AIDS, the silence surrounding HIV infection is due to the fear of being identified with marginalised and, so called, 'deviant behaviours' that are still associated with AIDS infection, such as prostitution, homosexuality and the use of illicit drugs' (Monteiro et al. 2016, 9).

Smith highlights the 'fault lines' characteristic of some faith responses to HIV, namely stigma, patriarchy, the 'raid and rescue' approaches to working with orphans and sex workers, and controversies around sexuality, sexual orientation and homosexuality. Smith concludes with a quotation from a powerful statement made by a group of religious leaders which attempts to address some of these fault lines. The meeting was convened by UNFPA inside the UN itself, in parallel with the UN General Assembly Meetings in 2014. This meeting inspired the work which led to the UNFPA document cited earlier: *Religion, Women's Health and Rights,* and is reproduced in full in that publication:

> Not in our name should anyone be denied access to basic healthcare, nor should a child or an adolescent be denied knowledge of and care for her/his body. Not in our name should any person be denied their human rights. We affirm that sexual and reproductive health are part of human rights, and as such, must be guaranteed by governments. We note in particular the importance of preventing gender-based discrimination, violence and harmful practices;

upholding gender justice; ensuring that every pregnancy is wanted and that every birth is safe; providing age-appropriate sexuality education; promoting the health, education and participation of youth and adolescents; preventing, treating and caring for people with HIV/AIDS; supporting family planning; and respecting the human body (UNFPA 2016, 79).

Annex 8.1: Comparison of PD2001 and Strategy2001

Strategic goal (UNAIDS Strategy)	Equivalent reference (Political Declaration)	Commentary
1. To ensure an extraordinary response to the epidemic which includes: the full engagement of top-level leaders; measurable goals and targets; effective policies and programmes supported by improved epidemiological and strategic information; adequate and sustained financial resources; and integration of HIV/AIDS prevention and care strategies into mainstream planning and development efforts.	1. We, heads of State and Government and representatives of States and Governments, …convened as a matter of urgency, to review and address the problem of HIV/… as well as to secure a global commitment to… intensification of national, regional and international efforts to combat it in a comprehensive manner; 47. By 2003, establish time-bound national targets to achieve the internationally agreed global prevention goal to reduce by 2005 HIV prevalence among young men and women aged 15 to 24 in the most affected countries by 25 per cent and by 25 per cent globally by 2010, 95. Develop appropriate monitoring and evaluation mechanisms …with adequate epidemiological data 98. Support data collection and processing 37. By 2003, ensure the development of …financing plans for combating HIV/AIDS. 38. By 2003, integrate HIV/AIDS prevention, care, treatment and support and impact-mitigation priorities into the mainstream of development planning	Ten paragraphs of PD2001, 36-46, affirm the importance of strong political leadership, stating the importance of national government leadership for an effective response and the necessity of partnerships with civil society, business and private sectors (General Assembly Resolution 2001, 36-46). In PD2001, 37-93, the commitments reflect all the main elements listed in the 12 leadership and core actions statements of Strategy2001 (UNAIDS 2001, 14). Equivalent
2. To develop policies, legislation	62. By 2003, in order to complement prevention	PD2001 reflects Strategy2001 well in this section- Equivalent

Strategic goal (UNAIDS Strategy)	Equivalent reference (Political Declaration)	Commentary
and programmes which address individual and societal vulnerability to HIV/AIDS and lessen its socioeconomic impacts, by focusing on enabling strategies which operate in the context of overall poverty reduction strategies and human development priorities and to develop the coping strategies required to address the impact of the epidemic in productive sectors.	programmes.. have in place in all countries strategies, policies and programmes that identify and begin to address those factors that make individuals particularly vulnerable to HIV infection, including underdevelopment, economic insecurity, poverty…	
3. To reduce the stigma associated with HIV and AIDS and to protect human rights through personal and political advocacy and the promotion of policies that prevent discrimination and intolerance and enable more open discussion of sexuality as an important part of human life.	66. Ensure non-discrimination and full and equal enjoyment of all human rights through the promotion of an active and visible policy of de-stigmatization of children orphaned and made vulnerable by HIV/AIDS; 58. By 2003, enact, strengthen or enforce, as appropriate, legislation, regulations and other measures to eliminate all forms of discrimination against and to ensure the full enjoyment of all human rights and fundamental freedoms by people living with HIV/AIDS and members of vulnerable groups, in particular to ensure their access to, inter alia, education, inheritance, employment, health care, social and health services, prevention, support and treatment, information and legal protection, while respecting their privacy and confidentiality; and develop strategies to combat stigma and social exclusion connected with the epidemic;	PD2001 is missing any reference to more open discussion of sexuality. Thus weaker
4. To expand efforts to support	56. By 2005, develop and make significant	PD2001 reflects Strategy2001 well in this section and goes further

Strategic goal (UNAIDS Strategy)	Equivalent reference (Political Declaration)	Commentary
community-focused action on the epidemic by affirming and strengthening the capacity of local communities to be assertively involved in all aspects of the response.	progress in implementing comprehensive care strategies to: strengthen family and community-based care, including that provided by the informal sector, and health-care systems to provide and monitor treatment to people living with HIV/AIDS, including infected children, and to support individuals, households, families and communities affected by HIV/AIDS; and improve the capacity and working conditions of health-care personnel, and the effectiveness of supply systems, financing plans and referral mechanisms required to provide access to affordable medicines, including antiretroviral drugs, diagnostics and related technologies, as well as quality medical, palliative and psychosocial care; 57. By 2003, ensure that national strategies are developed in order to provide psychosocial care for individuals, families and communities affected by HIV/AIDS;	than recommendations in Strategy2001- thus stronger
5. To protect children and young people from the epidemic and its impact through universal access to quality primary education and increased secondary school attendance, particularly for girls; life-skills education approaches for in-school and out-of school youth which are free of harmful gender stereotypes and include sexual education and the promotion of responsible sexual behaviour; the	63. By 2003, develop and/or strengthen strategies, policies and programmes which recognize the importance of the family in reducing vulnerability, inter alia, in educating and guiding children and take account of cultural, religious and ethical factors, to reduce the vulnerability of children and young people by ensuring access of both girls and boys to primary and secondary education, including HIV/AIDS in curricula for adolescents; ensuring safe and secure environments, especially for young girls; expanding good-quality, youth-friendly	PD2001 gives significant attention to protecting children and young people from the HIV epidemic and its impact. It goes well beyond Strategy2001 with reference to the engagement of families in reducing vulnerability and in specifying additional details on caring for orphans and vulnerable children. Thus stronger

Strategic goal (UNAIDS Strategy)	Equivalent reference (Political Declaration)	Commentary
promotion of the rights of children, including their to access to information and youth-friendly reproductive and sexual health services; services to prevent mother-to- child transmission of HIV; education on ways to prevent harmful drug use and to reduce the consequences of abuse; and early support to children affected by HIV/AIDS, in particular orphans.	information and sexual health education and counselling services; strengthening reproductive and sexual health programmes; and involving families and young people in planning, implementing and evaluating HIV/AIDS prevention and care programmes, to the extent possible; 47...... as well as to challenge gender stereotypes and attitudes, and gender inequalities in relation to HIV/AIDS 53. By 2005, ensure that at least 90 per cent, and by 2010 at least 95 per cent of young men and women aged 15 to 24 have access to the information, education, including peer education and youth-specific HIV education, and services necessary to develop the life skills required to reduce their vulnerability to HIV infection, in full partnership with young persons, parents, families, educators and health-care providers;Children orphaned and affected by HIV/AIDS need special assistance 65. By 2003, develop and by 2005 implement national policies and strategies to build and strengthen governmental, family and community capacities to provide a supportive environment for orphans and girls and boys infected and affected by HIV/AIDS, including by providing appropriate counselling and psychosocial support, ensuring their enrolment in school and access to shelter, good nutrition and health and social services on an equal basis with other	

Strategic goal (UNAIDS Strategy)	Equivalent reference (Political Declaration)	Commentary
	children; and protect orphans and vulnerable children from all forms of abuse, violence, exploitation, discrimination, trafficking and loss of inheritance; 66. Ensure non-discrimination and full and equal enjoyment of all human rights through the promotion of an active and visible policy of de-stigmatization of children orphaned and made vulnerable by HIV/AIDS; 67. Urge the international community, particularly donor countries, civil society, as well as the private sector, to complement effectively national programmes to support programmes for children orphaned or made vulnerable by HIV/AIDS in affected regions and in countries at high risk and to direct special assistance to sub-Saharan Africa;	
6. To meet the HIV/AIDS-related needs of girls and women and to address the circumstances that disadvantage women with respect to HIV/AIDS while enhancing their abilities to contribute their knowledge and voice as a force for change. In particular, to promote the rights of girls and women and to address gender-based inequalities in access to information and services and to improve access for women to male and female condoms and voluntary counselling and testing	59. By 2005, …. develop and accelerate the implementation of national strategies that promote the advancement of women and women’s full enjoyment of all human rights; promote shared responsibility of men and women to ensure safe sex; and empower women to have control over and decide freely and responsibly on matters related to their sexuality to increase their ability to protect themselves from HIV infection; 60. By 2005, implement measures to increase capacities of women and adolescent girls to protect themselves from the risk of HIV	PD2001 includes most of the elements listed in Strategy2001. It is missing reference to women's role as a force for change. Thus weaker The provision of male and female condoms is referred to in PD2001, 52- under prevention, but not in the section on women and girls. Strategy2001 does not focus on increasing women’s own ability to protect themselves from HIV infection, but PD2001 repeats this in p59 and 60. PD2001 is weaker, since it places responsibility on women to protect themselves, rather than on states to protect their rights

Strategic goal (UNAIDS Strategy)	Equivalent reference (Political Declaration)	Commentary
within family planning clinics and other reproductive health settings, and to assure equitable access for HIV infected women to care and social support.	infection, principally through the provision of health care and health services, including for sexual and reproductive health, and through prevention education that promotes gender equality within a culturally and gender-sensitive framework; PD2001, 61. By 2005, ensure development and accelerated implementation of national strategies for women's empowerment, the promotion and protection of women's full enjoyment of all human rights and reduction of their vulnerability to HIV/AIDS through the elimination of all forms of discrimination, as well as all forms of violence against women and girls, including harmful traditional and customary practices, abuse, rape and other forms of sexual violence, battering and trafficking in women and girls;	
7. To expand efforts directly addressing the needs of those most vulnerable to, and at greatest risk of HIV infection. In particular, to advance a participatory approach to the development of specific strategies, policies and programmes which promote and protect the health of children in especially difficult circumstances; sex workers and their clients; injecting drug users and their sexual partners; men who have sex with men; persons confined in institutions and prison	48. By 2003, establish national prevention targets, recognizing and addressing factors leading to the spread of the epidemic and increasing people's vulnerability, to reduce HIV incidence for those identifiable groups, within particular local contexts, which currently have high or increasing rates of HIV infection, or which available public health information indicates are at the highest risk of new infection; 50. By 2005, develop and begin to implement national, regional and international strategies that facilitate access to HIV/AIDS prevention programmes for migrants and mobile workers,	Commitment 7 of Strategy2001 lists and names each of the key populations. Strategy2001 calls specifically for strengthening of legal, policy and programmatic action to address the vulnerability of children and the named key populations. In addition, it recommends HIV education for young people, calling for a more open discussion of sexuality. These elements are all missing from PD2001, which does not name key populations, but refers to them as 'identifiable groups' (General Assembly Resolution 2001, 48). Thus PD2001 is weaker in these areas In addition, PD2001, 52 calls for actions aimed at reducing risk behaviour- including abstinence and fidelity- rather than specific strategies, policies and programmes which promote and protect the health of key populations

Strategic goal (UNAIDS Strategy)	Equivalent reference (Political Declaration)	Commentary
populations; refugees and internally displaced persons; and men and women separated from their families due to their occupations or conflict situations.	including the provision of information on health and social services; 52. By 2005, ensure: that a wide range of prevention programmes which take account of local circumstances, ethics and cultural values, is available in all countries, particularly the most affected countries, including information, education and communication, in languages most understood by communities and respectful of cultures, aimed at reducing risk-taking behaviour and encouraging responsible sexual behaviour, including abstinence and fidelity; expanded access to essential commodities, including male and female condoms and sterile injecting equipment; harm-reduction efforts related to drug use; expanded access to voluntary and confidential counselling and testing; safe blood supplies; and early and effective treatment of sexually transmittable infections;	PD2001 is thus weaker in this area
8. To provide care and support to individuals, households and communities affected by HIV/AIDS, ensuring access to voluntary counselling and diagnostic services and the continuum of affordable clinical and home-based care and treatment (including antiretroviral therapy), essential legal, educational and social services, and psychosocial support and counselling	56. By 2005, develop and make significant progress in implementing comprehensive care strategies to: strengthen family and community-based care, including that provided by the informal sector, and health-care systems to provide and monitor treatment to people living with HIV/AIDS, including infected children, and to support individuals, households, families and communities affected by HIV/AIDS; and improve the capacity and working conditions of health-care personnel, and the effectiveness of supply systems, financing plans and referral mechanisms required to provide access to affordable	PD2001 reflects well the suggested commitments of Strategy2001. Equivalent PD2001 is missing reference to essential legal services, PD2001 Weaker PD2001 goes further than Strategy2001 on support for health care workers, and provides a greater focus on families and households, palliative care.

Strategic goal (UNAIDS Strategy)	Equivalent reference (Political Declaration)	Commentary
	medicines, including antiretroviral drugs, diagnostics and related technologies, as well as quality medical, palliative and psychosocial care;	
9. To promote the full participation of people living with and affected by HIV/AIDS in the response to the epidemic by ensuring safe opportunities for people to speak out and give testimony to their experience, to participate in national and local advisory bodies, and in planning and implementation of HIV/AIDS programmes.	37.... involve partnerships with civil society and the business sector and the full participation of people living with HIV/AIDS, those in vulnerable groups and people mostly at risk, particularly women and young people. 94. Conduct national periodic reviews with the participation of civil society, particularly people living with HIV/AIDS, vulnerable groups and caregivers, of progress achieved in realizing these commitments, identify problems and obstacles to achieving progress, and ensure wide dissemination of the results of these reviews;	PD2001 refers to the involvement of PLHIV in periodic reviews of national programmes- but not in national HIV planning and implementation. PD2001 is thus weaker PD2001 goes further than Strategy2001 by including PLHIV and those in vulnerable groups, at risk, women and young people… but calls for their inclusion in fewer activities.
10. To seek out actively and support the development of partnerships required to address the epidemic among the public sector and civil society, including the private sector. In particular, to foster those alliances required to improve access to essential information, services and commodities – including access to condoms, care and treatment including treatment of sexually transmitted infections – and to the technical and financial resources required to support prevention, care and treatment programmes.	46. Foster stronger collaboration and the development of innovative partnerships between the public and private sectors, and by 2003 establish and strengthen mechanisms that involve the private sector and civil society partners and people living with HIV/AIDS and vulnerable groups in the fight against HIV/AIDS; 29. Recognizing the fundamental importance of strengthening national, regional and sub-regional capacities to address and effectively combat HIV/AIDS and that this will require increased and sustained human, financial and technical resources through strengthened national action and cooperation and increased regional, sub-regional and international cooperation.	PD2001 calls for the development of innovative partnerships as suggested by Strategy2001 but does not include a strong recommendation on increasing financial resources to support HIV programmes. Thus weaker

Strategic goal (UNAIDS Strategy)	Equivalent reference (Political Declaration)	Commentary
11. To intensify efforts in sociocultural, biomedical and operations research required to accelerate access to prevention and care technologies, microbicides, diagnostics and HIV vaccines, and to improve our understanding of factors which influence the epidemic and actions which optimally address it.	70. Increase investment in and accelerate research on the development of HIV vaccines, while building national research capacity, especially in developing countries, and especially for viral strains prevalent in highly affected regions; in addition, support and encourage increased national and international investment in HIV/AIDS-related research and development, including biomedical, operations, social, cultural and behavioural research and in traditional medicine to improve prevention and therapeutic approaches; accelerate access to prevention, care and treatment and care technologies for HIV/AIDS (and its associated opportunistic infections and malignancies and sexually transmitted diseases), including female controlled methods and microbicides, and in particular, appropriate, safe and affordable HIV vaccines and their delivery, and to diagnostics, tests and methods to prevent mother-to-child transmission; improve our understanding of factors which influence the epidemic and actions which address it, inter alia, through increased funding and public/private partnerships; and create a conducive environment for research and ensure that it is based on the highest ethical standards;	PD2001 goes beyond Strategy2001 in the section on research - calling for increased investment and disaggregating the types of research necessary to provide solutions to the epidemic, for which at that time there was no widely available affordable treatment. Thus stronger
12. To strengthen human resource and institutional capacities required to address the epidemic, and in particular to support service providers engaged in the response to the epidemic within the education,	22. Noting the importance of establishing and strengthening human resources and national health and social infrastructures as imperatives for the effective delivery of prevention, treatment, care and support services;	PD2001 does not address the issue of strengthening and supporting service providers directly, in the way it is addressed in Strategy2001. Nevertheless, the issues of access to services, protection of the rights of workers, and strengthening the health infrastructure are covered in paragraphs 22 and 69.

Strategic goal (UNAIDS Strategy)	Equivalent reference (Political Declaration)	Commentary
health, judicial and social welfare sectors.	69. By 2003, develop a national legal and policy framework that protects in the workplace the rights and dignity of persons living with and affected by HIV/AIDS and those at the greatest risk of HIV/AIDS, in consultation with representatives of employers and workers, taking account of established international guidelines on HIV/AIDS in the workplace;	

Annex 8.2: Comparison of PD2006 and Strategy2006

Strategic goal and objectives (UNAIDS Strategy)	Strategy proposed outputs relating to countries	Equivalent reference (Political Declaration)	Commentary
Overarching goal of that UN system organizations, individually and collectively, contribute to the Millennium Development Goal of halting and beginning to reverse the spread of HIV and AIDS by 2015 and meeting the targets of the UNGASS Declaration of Commitment through: (9) Greater action and coordination of all relevant organizations of the UN system in response to the AIDS epidemic and HIV and AIDS issues effectively addressed in the UN workplace. Strengthened partnerships to mainstream HIV and AIDS issues in the development and humanitarian agendas of the UN system organizations.	(a) Coordinated, coherent, effective UN action, with stronger leadership, strategic positioning, capacity and increased accountability of the UN system to support responses to AIDS at global, regional, sub-regional, national and local levels, including cities and communities. (b) Increased awareness of the AIDS epidemic, its trends and impact, as well as effective approaches to curb the epidemic and strengthen leadership among government authorities, decision-makers and key opinion leaders at all levels to take action and enable expanded responses. (c) Broad-based partnerships that include government at national, regional and local levels, people living with HIV, civil society/nongovernmental organizations, community-based organizations, women, young people, faith-based organizations, the private sector, business and labour organizations, philanthropic entities, intergovernmental organizations for action on AIDS at global, regional and	16. Convinced that without renewed political will, strong leadership and sustained commitment and concerted efforts on the part of all stakeholders at all levels' including people living with HIV civil society and vulnerable groups, and without increased resources, the world will not succeed in bringing about the end of the pandemic; 18. Reaffirm our commitment to implement fully the Declaration of Commitment on HIV/AIDS,… and to achieve the internationally agreed development goals and objectives, including the Millennium Development Goals, in particular the goal to halt and begin to reverse the spread of HIV/AIDS, malaria and other major diseases… and the goal of achieving universal access to reproductive health by 2015, as set out at the International Conference on Population and Development; 20. Commit ourselves to pursuing all necessary efforts to scale up nationally driven, sustainable and comprehensive responses to achieve broad	PD2006, 16 Affirmation of need for strong political will, leadership and civil society engagement. PD2006, 18 Commitment to the MDG Goal. PD2006 18 also commits to ICPD goal- goes further than Strategy2006 PD2006, 20 Commitment to partnerships with PLHIV- but does not list key population groups- still refers to 'vulnerable groups'. PD2006 thus weaker than Strategy2006 PD2006, 50 Equivalent

	country levels. (d) Countries enabled to implement the “Three Ones” principle to “make the money work”. This includes establishing or strengthening of a single national AIDS authority with a broad-based multisectoral mandate, a single agreed national multisectoral AIDS action framework which drives alignment of all partners, including at the decentralized level, and one agreed national AIDS monitoring and evaluation system capable of producing high quality estimates on the status and trends of the epidemic, its impact, and the response to it8. (e) Strengthened capacity of international, national and local partners including governments, to implement effective programmes, taking into account the issue of human capacity in communities and workplaces.	multisectoral coverage for prevention, treatment, care and support, with full and active participation of people living with HIV, vulnerable groups, most affected communities, civil society and the private sector, towards the goal of universal access to comprehensive prevention programmes, treatment, care and support by 2010; 50. Call upon the Joint United Nations Programme on HIV/AIDS, including its Co-sponsors, to assist national efforts to coordinate the AIDS response, as elaborated in the “Three Ones” principles.	
1. Build capacity and leadership Strengthen national strategies, financing and programmes for HIV and AIDS, and integrate such initiatives into mainstream development planning; Accelerate global and regional responses to the epidemic;(9)		21. Emphasize the need to strengthen policy and programme linkages. linkages and coordination between HIV/AIDS, sexual and reproductive health, national development plans and strategies, including poverty eradication strategies, and to address, where appropriate, the impact of HIV/AIDS on national development plans and strategies	PD2006, 21 Commitment to include HIV in national development plans and strategies. Equivalent

2. Protect and promote human rights (With reference to PD2001) Ensure that measures are in place to eliminate all forms of HIV and AIDS-related discrimination, ensure the full enjoyment of all human rights by people living with, or made vulnerable by HIV and AIDS and advance the rights and social status of women. (11)	(a) Countries adopt and implement laws, regulations, policies and programmes aimed at promoting and protecting the human rights of individuals affected by HIV and AIDS and members of vulnerable groups, including those aimed specifically, at addressing stigma and discrimination.	29. Commit ourselves to intensifying efforts to enact, strengthen or enforce, as appropriate, legislation, regulations and other measures to eliminate all forms of discrimination against and to ensure the full enjoyment of all human rights and fundamental freedoms by people living with HIV and members of vulnerable groups	PD2006, 29 Commits to ensure enjoyment of all human rights as per Strategy2006. Equivalent
3. Strengthen and accelerate HIV prevention and vulnerability reduction (With reference to PD2001) Declaration commits the global community to: a strengthening and acceleration of efforts to prevent new infections (with particular attention to women, men, young men and especially young women, newborns, migrants and mobile workers); implementation of universal precautions in health-care settings; and the promotion of effective prevention in the world of work. (With reference to PD2001) The Declaration also urges implementation of strategies to reduce the vulnerability that increases HIV risk and/or exacerbates the epidemic's impact on individuals, families and communities. (p11)	(a) Countries enabled to establish, implement and scale up HIV prevention responses, particularly addressing the needs of children and young people, women and groups at high risk of exposure to HIV such as injecting drug users, sex workers, men who have sex with men, migrants and mobile workers. (b) Policies and programmes implemented to empower women and adolescent girls to reduce their vulnerability and to protect themselves from the risk of HIV infection. (c) Countries enabled to develop, implement and scale up strategies, policies and programmes that identify and address factors that make individuals and communities vulnerable to, and at greater risk of HIV infection. This has to be done at	22. Reaffirm that the prevention of HIV infection must be the mainstay of national…, and therefore commit ourselves to intensifying efforts to ensure that a wide range of prevention programmes that take account of local circumstances, ethics and cultural values is available in all countries…., including information, education and communication, in languages most understood by communities and respectful of cultures, aimed at reducing risk-taking behaviours and encouraging responsible sexual behaviour, including abstinence and fidelity; expanded access to essential commodities, including male and female condoms and sterile injecting equipment; harm-reduction efforts related to drug use; expanded access to voluntary and confidential counselling and testing; safe blood supplies; and early and effective treatment of sexually transmitted	PD2006, 22 affirms importance of HIV prevention, but does not mention key populations, and includes limited wording on respect for culture and including responsible sexual behaviour, abstinence and fidelity. Weaker PD2006, 30 goes further than Strategy2006 in expressing right of women to take control over their sexuality and decide, including access to sexual and reproductive health care services. (PD2006 stronger in this area) PD2006, 31 also goes further than Strategy2006 re: women's empowerment

	national, regional and local levels. (d) Countries enabled to adopt and implement national policies and strategies to build and strengthen governmental, family and community and household capacities to provide a supportive environment for girls and boys affected by HIV and AIDS.	infections; 30. Pledge to eliminate gender inequalities, gender-based abuse and violence; increase the capacity of women and adolescent girls to protect themselves from the risk of HIV infection… ensure women can exercise right- to have control and -decide freely on matters.. sexuality 31. Commit ourselves to strengthening legal, policy, administrative and other measures for the promotion and protection of women's full enjoyment of all human rights and the reduction of their vulnerability to HIV/AIDS	
4. Facilitate the provision of care, support and treatment (With reference to PD2001) The Declaration commits countries to the adoption and implementation of comprehensive care strategies, including the provision of antiretroviral drugs and needed psychosocial care for individuals, families and communities affected by HIV and AIDS. (12)	(a) National, regional and international strategies adopted and under implementation to strengthen health-care systems to provide equitable delivery of services for the diagnosis, support, care and treatment of HIV, including expanded capacity to procure and deliver an uninterrupted supply of HIV medicines and diagnostics. Synergy between prevention and treatment, care and support must be harnessed. (b) Countries enabled to strengthen family-based care system and community-based care system to provide and monitor treatment, support to people living with HIV,	34. Commit ourselves to expanding to the greatest extent possible, supported by international cooperation and partnership, our capacity to deliver comprehensive HIV/AIDS programmes in ways that strengthen existing national health and social systems 36. Commit ourselves, invite international financial institutions and the Global Fund to Fight AIDS, Tuberculosis and Malaria…., strengthening of HIV/AIDS programmes and health systems and for addressing human resources gaps, including the development of alternative and simplified service delivery models and	PD2006, 34- Commits to strengthening national health care systems.- Equivalent Many references commit to the provision of HIV prevention, treatment care and support services- e.g. PD2006, 18, 18, 20. PD2006, 36 Commits to community-level care models Equivalent PD2006, 46 Encourages pharmaceutical companies, donors, multilateral organizations and other partners to develop public-private partnerships in support of research and development and technology

	including treatment literacy and adherence, and equitable access to HIV related medicines, taking into account the unequal burden of AIDS on women in many regions. (c) Public-private partnerships actively promoted to scale up coverage in provision of care, treatment and support, and prevention in countries.	the expansion of the community-level provision of HIV/AIDS prevention, treatment, care and support, as well as other health and social services; 46. Encourage pharmaceutical companies, donors, multilateral organizations and other partners to develop public-private partnerships in support of research and development and technology transfer, and in the comprehensive response to HIV/AIDS;	transfer, and in the comprehensive response to HIV/AIDS. Equivalent
5. Alleviate socioeconomic impact and address special situations (With reference to PD2001) The Declaration commits the global community to: evaluate and address, through multisectoral strategies, the social and economic impact of HIV and AIDS; develop and implement national policies and strategies that provide a supportive environment to children orphaned and made vulnerable by HIV and AIDS and that prevent discrimination against and promote de-stigmatization of such children; relieve the epidemic's impact on women and girls; effectively address special situations,	(a) Countries enabled to integrate HIV and AIDS as emergency and development issues, into national, local and sector development processes and instruments. This includes development and implementation of sector-specific strategies to alleviate the economic and social impact of the AIDS epidemic, with particular attention to women, girls and children affected by HIV and AIDS as well as human resource protection. (b) National, sub-regional and international policies and strategies adopted to incorporate HIV and AIDS disaster preparedness, risk reduction, awareness, prevention, care and treatment plans and interventions in conflict and post-conflict, humanitarian crisis and natural disaster situations.	32. Commit ourselves also to addressing as a priority the vulnerabilities faced by children affected by and living with HIV….promoting child-oriented HIV/AIDS policies and programmes and increased protection for children orphaned and affected by HIV/AIDS 37. Reiterate the need for Governments, United Nations agencies, regional and international organizations and non-governmental organizations involved with the provision and delivery of assistance to countries and regions affected by conflicts, humanitarian emergencies or natural disasters to incorporate HIV/AIDS prevention, care and treatment elements into their plans and programmes	PD2006 23,28, 34 give several references to integration of HIV services into health sector responses. Equivalent PD2006, 32 specifically refers to children. PD2006 37 broadly reflects Strategy2006 re humanitarian responses. Equivalent

such as emergency situations and HIV and AIDS among peacekeepers and national uniformed services; develop a national legal and policy framework that protects in the workplace the rights and dignity of persons living with HIV and affected by AIDS and those at greatest risk of HIV in consultation with representatives of employers and workers, taking account of established international guidelines on HIV and AIDS in the workplace. (13)			
6. Strengthen HIV and AIDS-related research and development and develop mechanisms for follow-up, monitoring and evaluation (With reference to PD2001) The Declaration commits the global community to increase investments in HIV and AIDS-related research and development, enhance development of national and international research infrastructures, and carry out independent ethical evaluations of all research protocols. The Declaration also calls for development and implementation of appropriate mechanisms to monitor and assess progress in implementing the commitments set forth in the Declaration.	(a) Up-to-date sex- and age-disaggregated data, information and knowledge on the status, trends and impact of the AIDS epidemic and the response; (b) operational research on effective responses; (c) promotion of research on HIV vaccines and microbicides and other female controlled methods and therapeutics.	45. Commit ourselves to intensifying investment in and efforts towards the research and development of new, safe and affordable HIV/AIDS-related medicines, products and technologies, such as vaccines, female-controlled methods and microbicides, paediatric antiretroviral formulations,	No reference in PD2006 to disaggregated data or strategic information; 2006, 49 and 50 refer to monitoring and evaluation. PD2006 weaker PD2006,45 Equivalent

7. Mobilize resources (With reference to PD2001) The Declaration calls on the global community to mobilize, by 2005, annual expenditures on HIV and AIDS in low- and middle-income countries of between US$ 7 billion and US$ 10 billion, drawing on multiple sources. To further the extraordinary resource mobilization required by the global epidemic, the Declaration endorses establishment of a global health fund and the launching of a global fundraising drive (14)	(a) Mobilization and use of financial resources from national budgets, donor countries, nongovernmental and intergovernmental organizations, philanthropic entities, the private sector and individuals in the response to AIDS. (b) Countries in need, regardless of prevalence, enabled to identify and access human and technical resources for priority AIDS activities.	36. Commit ourselves, invite international financial institutions and the Global Fund to Fight AIDS, Tuberculosis and Malaria, according to its policy framework, and encourage other donors, to provide additional resources to low- and middle -income countries for the strengthening of HIV/AIDS programmes and health systems and for addressing human resources gaps, 40. Recognize that the Joint United Nations Programme on HIV/AIDS has estimated that 20 to 23 billion United States dollars per annum is needed by 2010 to support rapidly scaled-up AIDS responses in low- and middle-income countries, and therefore commit ourselves to taking measures to ensure that new and additional resources are made available from donor countries and also from national budgets and other national sources; 35. Undertake to reinforce, adopt and implement, where needed, national plans and strategies, supported by international cooperation and partnership, to increase the capacity of human resources for health to meet the urgent need for the training and retention of a broad range of health workers	PD2006, 36 and 40 refer to mobilization of financial resources from donor and national sources. - Equivalent PD2006, 35 refers to importance of increasing human resources for health-Equivalent

Annex 8.3: Comparison of PD2011 and Strategy2011

Strategic goal (UNAIDS Strategy)	Equivalent reference (Political Declaration)	Commentary
Sexual transmission of HIV reduced by half, including among young people, men who have sex with men and transmission in the context of sex work (7)	62. Commit to working towards reducing sexual transmission of HIV by 50 per cent by 2015	PD2011 equivalent target to Strategy2011, but omits specificity of young people, men who have sex with men and transmission in the context of sex work. Qualified by 'working towards', thus weakened
Vertical transmission of HIV eliminated, and AIDS-related maternal mortality reduced by half (7)	64. Commit to working towards the elimination of mother-to-child transmission of HIV by 2015 and substantially reducing AIDS-related maternal deaths	For reduction of maternal mortality, Strategy2011 (reduction by half) is stronger than PD2011 (substantially reducing). Vertical transmission is more neutral than 'mother-to-child transmission', as it does not apportion blame to the mother. PD2011 Commitment qualified by 'working towards' These goals will be achieved through implementation of the Global Plan Towards the Elimination of New HIV Infections among Children and Keeping their Mothers Alive, launched at the High-Level Meeting
All new HIV infections prevented among people who use drugs (7)	63. Commit to working towards reducing transmission of HIV among people who inject drugs by 50 per cent by 2015 59. Commit to redouble HIV prevention efforts by taking all measures to implement comprehensive, evidence-based prevention approaches, taking into account local circumstances, ethics and cultural values, including through, but not limited to: (h) Giving consideration, as appropriate, to implementing and expanding risk and harm reduction programmes, taking into account the	Strategy2011 (all new infections prevented among people who use drugs) differs from the Declaration (50% reduction of transmission among people who inject drugs). Commitment is qualified by 'working towards' and reducing the scope of the target group, thus weakened. PD2011, 59 (h) qualifies harm reduction twice by "as appropriate" and "in accordance with national legislation"- thus weakened.

Strategic goal (UNAIDS Strategy)	Equivalent reference (Political Declaration)	Commentary
	WHO, UNODC, UNAIDS Technical Guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users in accordance with national legislation (p59)	
Universal access to antiretroviral therapy for people living with HIV who are eligible for treatment (7)	66. Target of working towards having 15 million people living with HIV on antiretroviral treatment by 2015	Different measures between the Strategy2011 (universal access) and PD2011, 66 (15 million people) but are equivalent (if universal access understood to be 80%, which by 2015 would be between 14 and 15 million people). Commitment is qualified by 'working towards'. Equivalent- except for qualification of 'working towards'
Tuberculosis deaths among people living with HIV reduced by half (7)	75. Commit by 2015 to work towards reducing tuberculosis deaths in people living with HIV by 50 per cent	Equivalent- except for qualification of 'working towards'
People living with HIV and households affected by HIV are addressed in all national social protection strategies and have access to essential care and support (7)	82. Commit to strengthen national social and child protection systems and care and support programmes for children, in particular for the girl child, and adolescents affected by and vulnerable to HIV, as well as their families and caregivers, including through the provision of equal opportunities to support the development to full potential of orphans and other children affected by and living with HIV, especially through equal access to education, the creation of safe and non-discriminatory learning environments, supportive legal systems and protections, including civil registration systems, and provision of comprehensive information and support to children and their families and caregivers, especially age-appropriate HIV information to assist children living with HIV as	No direct comparison. PD2011, 82 of the Declaration offers the closet link, although focuses on children and is weaker than the Strategy (which has a more universal call for services rather than simply to "strengthen" them). PD2011, 82 provides more detail than the Strategy2016 in calling for specific actions for children, but in the end is not as strong- because it does not actually specify access to essential care and support services Paragraphs like this are characteristic of the influence of the traditional religio-cultural and national sovereignty discourses on the negotiations. Supporters will provide many additional details to paragraphs on children and families, whilst omitting references to the services essential to them, or these qualifying with phrases such as 'consistent with their evolving capacities'

Strategic goal (UNAIDS Strategy)	Equivalent reference (Political Declaration)	Commentary
	they transition through adolescence, consistent with their evolving capacities	
Countries with punitive laws and practices around HIV transmission, sex work, drug use or homosexuality that block effective responses reduced by half (7)	78. Commit to review, as appropriate, laws and policies that adversely affect the successful, effective and equitable delivery of HIV prevention, treatment, care and support programmes to people living with and affected by HIV, and consider their review in accordance with relevant national review frameworks and time frames	PD2011,78 has no date. PD2011, 78 qualifies it twice with "as appropriate" and "in accordance with relevant national review frameworks and timeframes". Language is different ('punitive laws & practices' vs. 'laws and policies that adversely affect …') thus weakened. Strategy2011 is more specific and stronger in mentioning key modes of transmission as well as noting the need for halving of punitive laws vs. "committing to review" the adverse laws.
HIV-related restrictions on entry, stay and residence eliminated in half of the countries that have such restrictions (7)	79. Encourage Member States to consider identifying and reviewing any remaining HIV-related restrictions on entry, stay and residence so as to eliminate them	PD2011, 79 (eliminate) is stronger than Strategy2011 (elimination in half of countries having restrictions) yet qualifies it heavily with "consider identifying and reviewing" as opposed to doing it.
HIV-specific needs of women and girls are addressed in at least half of all national HIV responses (7)	81. Commit to ensuring that national responses to HIV and AIDS meet the specific needs of women and girls	PD2011, 81 ([all] national responses) is in principle stronger than the Strategy2011 (at least half).
Zero tolerance for gender-based violence (7)	53. Pledge to eliminate gender inequalities and gender-based abuse and violence	PD2011, 53 is stronger - where Strategy2011 talks about zero tolerance and only in relation to gender-based violence, PD commits to eliminating inequality, abuse and violence.
Financing—no target	86. Commit to working towards closing the global HIV and AIDS resource gap by 2015, currently estimated by UNAIDS at US 6 billion annually 88. Commit by 2015, through a series of incremental steps and through our shared responsibility, to reach a significant level of annual global expenditure on HIV and AIDS, while recognizing that the overall target estimated by	Resource investment target drawn from UNAIDS investment approach paper as published in The Lancet PD2011 stronger than strategy

Strategic goal (UNAIDS Strategy)	Equivalent reference (Political Declaration)	Commentary
	UNAIDS is between US$22 and US$24 billion in low- and middle- income countries, by increasing national ownership of HIV and AIDS responses through greater allocations from national resources and traditional sources of funding including official development assistance	
National determinants Countries need better information about the determinants, dynamics and impact of their epidemic to develop cost-effective responses engaging people in need, including people at higher risk and vulnerable to HIV (34) Comprehensive sexuality education empowers young people to make informed decisions (34) Family-centred approaches recognize that social norms are set at the family and community level and that parents, other kin and community leaders can have a defining impact (34) Effective prevention depends on such engagement and in involving the groups at higher risk in designing and delivering programmes. Innovative approaches that involve people living with HIV, such as	National determinants 29. Note that many national HIV prevention strategies inadequately focus on populations that epidemiological evidence shows are at higher risk, specifically men who have sex with men, people who inject drugs and sex workers, and further note, however, that each country should define the specific populations that are key to its epidemic and response, based on the epidemiological and national context 59. Commit to redouble HIV prevention efforts by taking all measures to implement comprehensive, evidence-based prevention approaches, taking into account local circumstances, ethics and cultural values, including through, but not limited to: 55. Commit to increase national ownership of HIV and AIDS responses, while calling on the United Nations system, donor countries, the Global Fund to Fight AIDS, TB and Malaria….to support Member States in ensuring that nationally driven, credible, costed, evidence-based, inclusive and comprehensive national HIV and AIDS strategic	National determinants PD2011, 2, 29, 55 and 59 all state the importance of countries defining their epidemics according to their national priorities and local epidemiological and social circumstances, yet provide no substantive analysis of why specific, targeted interventions are needed in different countries, or what these differentiated approaches should look like. PD2011 is therefore weakened by these qualifications Strategy2011, p34. provides examples of targeted interventions, and countries who have taken bold leadership eg: South Africa, where mass mobilizations have been implemented using the whole apparatus of democracy to bring together HIV services, knowledge of status and health-changing behaviour; Kenya's scaling up of voluntary male circumcision in the context of HIV education and behaviour change; and the significant scaling up of access to methadone, needle and syringe programmes and ART for people who use drugs in Malaysia, despite remaining challenges. PD2011 is limited in its potential to articulate a clear way forward for countries based on solid analysis of their distinctive epidemiological drivers and key populations. PD2011 does not draw sufficiently on Strategy2011 to ensure that it is a political plan of action informed by the best data and analysis

Strategic goal (UNAIDS Strategy)	Equivalent reference (Political Declaration)	Commentary
"Positive Health, Dignity and Prevention" are urgently needed. Political and programmatic commitment to involving affected communities must be ensured. No more denial of the harmful social, sexual and gender norms that drive vulnerability: the social exclusion of particular groups; the refusal to admit the existence of men who have sex with men; the marginalization of people who use drugs; and gender inequality, violence and other forms of abuse directed towards women. Leaders must be enlisted to support a prevention revolution by giving them greater recognition for their efforts when they do the right thing in responding to HIV, even if it does not serve short-term populist goals.	plans are, by 2013, funded and implemented with transparency, accountability and effectiveness in line with national priorities	
	23. Welcome the adoption of the Convention on the Rights of Persons with Disabilities,4 and recognize the need to take into account the rights of persons with disabilities as set forth in that Convention, in particular with regard to health, education, accessibility and information, in the formulation of our global response to HIV and AIDS	The Convention on the Rights of Persons with Disabilities (CRPD) recognizes the importance of fulfilling reproductive rights for persons with disabilities, particularly women and girls, and includes the most expansive language on reproductive rights of any UN human rights convention. The reproductive rights specifically enumerated in the CRPD include the rights "to decide freely and responsibly on the number and spacing of their children and to have access to age-appropriate information, reproductive and family planning education", "to retain their fertility on an equal basis with others", including for children with disabilities, and to access health care and programmes on an equal basis with others, "including in the area of sexual and reproductive health and population based

Strategic goal (UNAIDS Strategy)	Equivalent reference (Political Declaration)	Commentary
		public health programmes" (UNFPA 2016, 23). (In PD2011 it is welcomed as a new document, in PD2016 it will be affirmed).

The original analysis for this table was carried out by Kent Buse and his team at UNAIDS, I have added to their analysis, and used the model for analysis of other PDs.(Buse 2011)

Annex 8.4: Comparison of PD2016 and Strategy2016

Strategic goal (UNAIDS Strategy)	Equivalent reference (Political Declaration)	Commentary
Goals (UNAIDS 2015c, 15) • Fewer than 500 000 people newly infected with HIV • Fewer than 500 000 people dying from AIDS-related causes • Elimination of HIV-related discrimination	56. Commit to targets for 2020 to work towards reducing the global numbers of people newly infected with HIV to fewer than 500,000 per annum and people dying from AIDS-related causes to fewer than 500,000 per annum, as well as to eliminate HIV-related stigma and discrimination;	Equivalent- but qualified by 'work towards'
Targets (UNAIDS 2015c, 8) Target 1: 90 percent of people (children, adolescents and adults) living with HIV know their status, 90 percent of people living with HIV who know their status are receiving treatment and 90 percent of people on treatment have suppressed viral loads.	60. (a): Commit to 90-90-90 treatment targets,2 and to ensuring that 30 million people living with HIV access treatment by 2020 with special emphasis on providing 1.6 million children (0-14 years of age) with antiretroviral therapy by 2018 and that children, adolescents and adults living with HIV know their status and are immediately offered and sustained on affordable and accessible quality treatment to ensure viral load suppression and underscore in this regard the urgency of closing the testing gap; 60 (b): Commit to using multiple strategies and modalities, including, when possible, voluntary, confidential, fully-informed and safe community-based testing, according to national context, to reaching the millions of people who do not know their status, including those living with HIV and to providing pre-test information, counselling, post-test referrals and follow-up to facilitate linkages to care, support and treatment services, including viral load monitoring and to addressing	PD2016, 60a commits to target 1 and strengthens the commitment towards children, specifying a treatment target by 2018, with 'special emphasis on providing 1.6 million children with antiretroviral therapy by 2018' PD2016, 60b further strengthens the response to target 1 providing additional detailed strategies to reach people with testing and treatment. PD2016, 65 a-d, also strengthens target 1 further by articulating a series of specific targets for each geographic region

Strategic goal (UNAIDS Strategy)	Equivalent reference (Political Declaration)	Commentary
	socioeconomic barriers to testing and treatment, including legal, regulatory barriers to community testing, and commit to expanding and promoting voluntary and confidential HIV testing and counselling, including provider-initiated HIV testing and counselling and to intensifying national testing promotion campaigns for HIV and other sexually transmitted infections;	
Target 2: Zero new HIV infections among children and mothers are alive and well.	60 (c): Commit to taking all appropriate steps to eliminate new HIV infections among children and ensure that their mothers' health and well-being are sustained through immediate and lifelong treatment, including for pregnant and breastfeeding women living with HIV through early infant diagnosis, dual elimination with congenital syphilis, and treatment of their male partners, adopting innovative systems that track and provide comprehensive services to mother-infant pairs through the continuum of care, expanding case-finding of children in all health-care entry points, improving linkage to treatment, increasing and improving adherence support, developing models of care for children differentiated by age groups, eliminating preventable maternal mortality and engaging male partners in prevention and treatment services, and taking steps towards achieving WHO certification of elimination of mother-to-child HIV transmission;	Target 2 to eliminate new infections among children, keeping mothers alive and well, is also strengthened with additional detail on providing lifelong HIV treatment for mothers, treatment for male partners, and other details- see PD2016, 60.(c)
Target 3: 90 percent of young people are empowered with the skills, knowledge and capability to protect	62. (c) Commit to accelerate efforts to scale up scientifically accurate age-appropriate comprehensive education, relevant to cultural	Target 3 is not reflected in full but qualified: PD2016, 62(c), commits to 'accelerate efforts to scale up scientifically accurate age-appropriate comprehensive education', and is compromised by the

Strategic goal (UNAIDS Strategy)	Equivalent reference (Political Declaration)	Commentary
themselves from HIV.	contexts, that provides adolescent girls and boys and young women and men, in and out of school, consistent with their evolving capacities, with information on sexual and reproductive health and HIV prevention, gender equality and women's empowerment, human rights, physical, psychological and pubertal development and power in relationships between women and men, to enable them to build self-esteem, informed decision-making, communication and risk reduction skills and develop respectful relationships, in full partnership with young persons, parents, legal guardians, caregivers, educators and health-care providers, in order to enable them to protect themselves from HIV infection;	phrases 'relevant to cultural contexts', 'consistent with their evolving capacities', and 'to enable them to build self-esteem, informed decision-making, communication and risk reduction skills and develop respectful relationships'.
Target 4: 90 percent of women and men, especially young people and those in high-prevalence settings, have access to HIV combination prevention and sexual and reproductive health services.	62. (a) Recognize that the AIDS response can only be Fast-Tracked by protecting and promoting access appropriate, high-quality, evidence-based HIV information, education and services without stigma and discrimination with full respect for rights to privacy, confidentiality and informed consent and reaffirm that comprehensive prevention programmes, treatment, care and support of HIV must be the cornerstone of national, regional and international responses to the HIV epidemic; 62. (b) Commit to redouble non-discriminatory HIV-prevention efforts by taking all measures to implement comprehensive, evidence-based prevention approaches to reduce new HIV infections, including by conducting public	Target 4, on access to 'combination HIV prevention' and SRH services, is compromised by the substitution of the term 'comprehensive prevention programmes' in PD2016, 62a-b. This is because the term combination prevention is very carefully defined by UNAIDS and includes a specific set of actions. Comprehensive HIV prevention, however is un-defined and therefore does not include all actions necessary for HIV prevention among key populations (UNAIDS 2016d, 10). This provides a loophole for countries to omit elements of combination prevention that are not acceptable to socially conservative groups. The commitment to the target is therefore weakened

Strategic goal (UNAIDS Strategy)	Equivalent reference (Political Declaration)	Commentary
	awareness campaigns and targeted HIV education to raise public awareness;	
Target 5: 27 million additional men in high-prevalence settings are voluntarily medically circumcised, as part of integrated sexual and reproductive health services for men.	62. (f) Encourage Member States with high HIV incidence to taking all appropriate steps ……and an additional 25 million young men are voluntarily medically circumcised by 2020 in high HIV incidence areas in and ensure the availability of 20 billion condoms in low-and middle-income countries;	Target 5, that an additional 27 million men are voluntarily medically circumcised, is modified to an additional 25 million by 2020, as an interim target in PD2016, 62f. The PD2016 targets are all set to 2030, which effectively strengthens this target by calling for faster progress.
Target 6: 90 percent of key populations, including sex workers, men who have sex with men, people who inject drugs, transgender people and prisoners, as well as migrants, have access to HIV combination prevention services.	62. (f) Encourage Member States with high HIV incidence to taking all appropriate steps to ensure that 90% of those at risk of HIV infection are reached by comprehensive prevention services, that 3 million persons at high risk access pre-exposure prophylaxis…..	Target 6, '90 percent of key populations, including sex workers, men who have sex with men, people who inject drugs, transgender people and prisoners, as well as migrants, have access to HIV combination prevention services', is also modified in PD2016, 62f to 'comprehensive HIV prevention', thus weakened. In addition, key populations are not named but covered by the term 'those at risk of HIV infection'. PD2016 effectively weakens the response to this target vs Strategy2016.
Target 7: 90 percent of women and girls live free from gender inequality and gender-based violence to mitigate the risk and impact of HIV	61. (c) Pledge to eliminate gender inequalities and gender-based abuse and violence, increase the capacity of women and adolescent girls to protect themselves from the risk of HIV infection, principally through the provision of health care and services, including, inter alia, sexual and reproductive health, as well as full access to comprehensive information and education, ensure that women can exercise their right to have control over, and decide freely and responsibly on, matters related to their sexuality, including their sexual and reproductive health, free of coercion, discrimination and	PD2016, 61c Strengthens the language on this target- calling for elimination vs 90% in Strategy2016.

Strategic goal (UNAIDS Strategy)	Equivalent reference (Political Declaration)	Commentary
	violence, in order to increase their ability to protect themselves from HIV infection, and take all necessary measures to create an enabling environment for the empowerment of women and to strengthen their economic independence, and, in this context, reiterate the importance of the role of men and boys in achieving gender equality;	
Target 8: 90 percent of people living with, at risk of and affected by HIV report no discrimination, especially in health, education and workplace settings.	62. (j) Commit to eliminate barriers, including stigma and discrimination in health-care settings, to ensure universal access to comprehensive HIV diagnostic, prevention, treatment, care and support for people living with, at risk of, and affected by HIV, persons deprived of their liberty, indigenous people, children, adolescents, young people, women, and other vulnerable populations; 63. (d) Underscore the need to mitigate the impact of the epidemic on workers, and their families, and their dependants, workplaces and economies……and call upon employers, trade and labour unions, employees and volunteers to take measures to eliminate stigma and discrimination, protect, promote and respect human rights and facilitate access to HIV prevention, treatment, care and support;	PD2016, 62. (j) effectively strengthens the commitment to target 8, calling for elimination of stigma and discrimination – rather than 90% reporting no discrimination.
Target 9: Overall financial investments for the AIDS response in low- and middle-income countries reach at least US$ 30 billion, with	59. (b) Commit to increasing and fully funding the AIDS response from all sources, including from innovative financing, and reaching overall financial investments in developing countries of	PD2016 modifies its commitment to target 9 again with an interim 2020 target, whilst it is lower $26bn vs $30 bn- it effectively strengthens and frontloads this commitment.

Strategic goal (UNAIDS Strategy)	Equivalent reference (Political Declaration)	Commentary
continued increase from the current levels of domestic public sources.	at least USD 26 billion/year by 2020, as estimated by UNAIDS, with continued increase from the current levels of domestic public and private sources, according to each country's capacity, supplemented by public and private international assistance and strengthened global solidarity, and urge all stakeholders to contribute to a successful 5th and subsequent replenishments of the Global Fund to Fight AIDS, Tuberculosis and Malaria;	
Target 10: 75 percent of people living with, at risk of and affected by HIV, who are in need, benefit from HIV-sensitive social protection.	62. (i) Encourage Member States to strengthen, national social and child protection systems to ensure that by 2020, 75% of people living with, at risk of, and affected by HIV, who are in need, benefit from HIV-sensitive social protection, including cash transfers and equal access to housing, and support programmes for children, in particular for orphans and street children, girls, and adolescents living with, at risk of, and affected by HIV, as well as their families and caregivers, including through the provision of equal opportunities to support the development of children to their full potential especially through equal access to early child development services, trauma and psychosocial support and education, as they transition through adolescence, the creation of safe and non-discriminatory learning environments, supportive legal systems and protections, including civil registration systems.	PD2016 modifies its commitment to target 9 again with an interim 2020 target. By maintaining the same figure of 75%, PD2016 effectively strengthens the commitment to this target and provides additional detail.
Target 5.6: Ensure universal access to sexual and reproductive health	5. Reaffirm the Universal Declaration on Human Rights, the International Covenant on Civil and	As a result of considerable action through 2015/6 during the negotiations towards the SDGs, including by UNAIDS in collaboration

Strategic goal (UNAIDS Strategy)	Equivalent reference (Political Declaration)	Commentary
and reproductive rights as agreed in accordance with the Programme of Action of the International Conference on Population and Development and the Beijing Platform for Action and the outcome documents of their review conferences (General Assembly Resolution 2015, 5.6). 'Women, the girl child and HIV and AIDS'. Statement by Botswana on behalf of SADC Stressing also that the lack of respect, protection, promotion and fulfilment of their human rights and fundamental freedoms, and insufficient access to the highest attainable standard of physical and mental health, including sexual and reproductive health and reproductive rights in accordance with the International Conference on Population and Development and the Beijing Declaration and Platform of Action and the outcome documents of their review conferences, aggravates the impact of the AIDS epidemic, especially among women and girls, increasing their vulnerability and endangering the survival of present and future generations (Botswana 2016, 2),	Political Rights, the International Covenant on Economic, Social and Cultural Rights, the Beijing Declaration and Platform for Action and the outcomes of its reviews; the outcome documents of the Twenty-third Special Session of the General Assembly, the Programme of Action of the International Conference on Population and Development, and the key actions for its further implementation, and the outcomes of its reviews, and notes the outcome documents of the regional review conferences, stressing that the outcome documents of the regional review conferences provide region-specific guidance on population and development beyond 2014 for each region that adopted the particular outcome document, the Convention on the Rights of the Child, the Convention on the Elimination of all Forms of Discrimination Against Women, the outcome document of the 2016 United Nations General Assembly Special Session on the World Drug Problem, the Declaration on the Elimination of Violence Against Women, and the Convention on the Rights of Persons with Disabilities; 14. Emphasize the continued importance, particularly given the 2015 World Health Organization Guidelines recommending that antiretroviral therapy be initiated for everyone living with HIV at any CD4 cell count, of a more integrated and systemic approach to addressing people's access to quality, people-centred health-care services in a more holistic manner, in the context of promoting the right to the enjoyment of the highest attainable standard of	with SADC, the concept and language of reproductive rights was included in SDG Target 5.5. The Strategy2016 takes this language further with a request for sexual and reproductive health and rights. PD2016 affirms the convention on the Rights of Persons with Disabilities and for the first time the Convention on the Elimination of Violence against Women. The Convention on the Rights of Persons with Disabilities (CRPD) recognizes the importance of fulfilling reproductive rights for persons with disabilities, particularly women and girls, and includes the most expansive language on reproductive rights of any UN human rights convention. The reproductive rights specifically enumerated in the CRPD include the rights "to decide freely and responsibly on the number and spacing of their children and to have access to age-appropriate information, reproductive and family planning education", "to retain their fertility on an equal basis with others", including for children with disabilities, and to access health care and programmes on an equal basis with others, "including in the area of sexual and reproductive health and population based public health programmes" (UNFPA 2016, 23) The outcome documents of the review conferences of Programme of Action of the International Conference on Population and Development and the Beijing Platform for Action also moved

Strategic goal (UNAIDS Strategy)	Equivalent reference (Political Declaration)	Commentary
Sexual and reproductive health and rights needs fully met to prevent HIV transmission (UNAIDS 2015c, 11)	physical and mental health and well-being, universal access to sexual and reproductive health and reproductive rights in accordance with the Programme of Action of the International Conference on Population and Development and the Beijing Platform for Action and the outcome documents of their review conferences, universal health coverage, social protection for people in vulnerable situations, local, national and international health and social protection systems strengthening, including community systems, integrated responses to address non-communicable diseases and HIV and AIDS, and preparedness to tackle emerging disease outbreaks, such as Ebola, Zika and those yet to be identified, and other health threats; 61. (b) Stress in that regard that the lack of protection and promotion of the human rights of all women and their sexual and reproductive health and reproductive rights in accordance with the Programme of Action of the International Conference on Population and Development, the Beijing Platform for Action and the outcome documents of their review conferences, and insufficient access to the highest attainable standard of physical and mental health, aggravates the impact of the epidemic especially amongst women and girls, increasing their vulnerability and endangering the survival of present and future generations;	forward in defining reproductive rights and taking forward a broader agenda for reproductive health for women, hence the significance of these mentions in PD2016 and omissions in previous PDs. The difference between the term ‘sexual and reproductive health and reproductive rights’ and ‘sexual and reproductive health and rights’ is that sexual rights encompass LGBT rights, which remain controversial for many. This analysis demonstrates that PD2016 is not as strong as Strategy2016 with regard to sexual and reproductive health and rights, but is stronger than any previous PD on HIV/AIDS in that it does take up the concept of reproductive rights.

Annex 9.1 Use of the term ‘women and girls’ and related terms in Political Declarations on HIV & AIDS

(a) 2001 Political Declaration

4. Noting with grave concern that all people, rich and poor, without distinction as to age, gender or race, are affected by the HIV/AIDS epidemic, further noting that people in developing countries are the most affected and that women, young adults and children, in particular girls, are the most vulnerable;

14. Stressing that gender equality and the empowerment of women are fundamental elements in the reduction of the vulnerability of women and girls to HIV/AIDS;

59. By 2005, bearing in mind the context and character of the epidemic and that, globally, women and girls are disproportionately affected by HIV/AIDS, develop and accelerate the implementation of national strategies that promote the advancement of women and women’s full enjoyment of all human rights; promote shared responsibility of men and women to ensure safe sex; and empower women to have control over and decide freely and responsibly on matters related to their sexuality to increase their ability to protect themselves from HIV infection;

60. By 2005, implement measures to increase capacities of women and adolescent girls to protect themselves from the risk of HIV infection, principally through the provision of health care and health services, including for sexual and reproductive health, and through prevention education that promotes gender equality within a culturally and gender-sensitive framework;

61. By 2005, ensure development and accelerated implementation of national strategies for women’s empowerment, the promotion and protection of women’s full enjoyment of all human rights and reduction of their vulnerability to HIV/AIDS through the elimination of all forms of discrimination, as well as all forms of violence against women and girls, including harmful traditional and customary practices, abuse, rape and other forms of sexual violence, battering and trafficking in women and girls;

(b) 2006 Political Declaration

7. Remain deeply concerned, however, by the overall expansion and feminization of the pandemic and the fact that women now represent 50 per cent of people living with HIV worldwide and nearly 60 per cent of people living with HIV in Africa, and in this regard recognize that gender inequalities and all forms of violence against women and girls increase their vulnerability to HIV/AIDS;

30. Pledge to eliminate gender inequalities, gender-based abuse and violence; increase the capacity of women and adolescent girls to protect themselves from the risk of HIV infection, principally through the provision of health care and services, including, inter alia, sexual and reproductive health, and the provision of full access to comprehensive information and education; ensure that women can exercise their right to have control over, and decide freely and responsibly on, matters related to their sexuality in order to increase their ability to protect themselves from HIV infection, including their sexual and reproductive health, free of coercion, discrimination and violence; and take all necessary measures to create an enabling environment for the empowerment of women and strengthen their economic independence; and in this context, reiterate the importance of the role of men and boys in achieving gender equality;

31. Commit ourselves to strengthening legal, policy, administrative and other measures for the promotion and protection of women's full enjoyment of all human rights and the reduction of their vulnerability to HIV/AIDS through the elimination of all forms of discrimination, as well as all types of sexual exploitation of women, girls and boys, including for commercial reasons, and all forms of violence against women and girls, including harmful traditional and customary practices, abuse, rape and other forms of sexual violence, battering and trafficking in women and girls;

(c) 2011 Political Declaration

21. Remain deeply concerned that globally women and girls are still the most affected by the epidemic and that they bear a disproportionate share of the caregiving burden, and that the ability of women and girls to protect themselves from HIV continues to be compromised by physiological factors, gender inequalities, including unequal legal, economic and social status, insufficient access to health care and services, including for sexual and reproductive health, and all forms of discrimination and violence, including sexual violence and exploitation against them;

41. Recognize that access to sexual and reproductive health has been and continues to be essential for HIV and AIDS responses, and that Governments have the responsibility to provide for public health, with special attention to families, women and children;

53. Pledge to eliminate gender inequalities and gender-based abuse and violence, increase the capacity of women and adolescent girls to protect themselves from the risk of HIV infection, principally through the provision of health care and services, including, inter alia, sexual and reproductive health, as well as full access to comprehensive information and education, ensure that women can exercise their right to have control over, and decide freely and responsibly on, matters related to their sexuality in order to increase their ability to protect themselves from HIV infection, including their sexual and reproductive health, free of coercion, discrimination and violence, and take all necessary measures to create an enabling environment for the

empowerment of women and strengthen their economic independence, and, in this context, reiterate the importance of the role of men and boys in achieving gender equality;

81. Commit to ensuring that national responses to HIV and AIDS meet the specific needs of women and girls, including those living with and affected by HIV, across their lifespan, through strengthening legal, policy, administrative and other measures for the promotion and protection of women's full enjoyment of all human rights and the reduction of their vulnerability to HIV through the elimination of all forms of discrimination, as well as all types of sexual exploitation of women, girls and boys, including for commercial reasons, and all forms of violence against women and girls, including harmful traditional and customary practices, abuse, rape and other forms of sexual violence, battering and trafficking in women and girls;

(d) 2016 Political Declaration

15. Emphasize that to guarantee the sustainability of HIV prevention, treatment, care, and support services, information and education, which are mutually reinforcing, these should be integrated with national health systems and services to address coinfections and co-morbidities, in particular tuberculosis, substance use and mental disorders, as well as sexual and reproductive health-care services, including prevention, screening and treatment for viral hepatitis and cervical cancer, as well as other sexually transmitted infections, including human papillomavirus, and services to respond to sexual and gender-based violence while noting the particular vulnerability of women and girls to these coinfections and co-morbidities;

33. Note with deep concern that the HIV epidemic remains a paramount health, development, human rights and social challenge inflicting immense suffering on countries, communities and families throughout the world, that since the beginning of the epidemic there have been an estimated 76 million HIV infections and that 34 million people have died from AIDS, that AIDS is the leading cause of death among women and adolescent girls of reproductive age (age 15-49) globally, and that around 14 million children have been orphaned due to AIDS, and that 6,000 new HIV infections occur every day, mostly among people in developing countries, and note with alarm that, among the 36.9 million people living with HIV, more than 19 million people do not know their status;

41. Remain deeply concerned that, globally, women and girls are still the most affected by the epidemic and that they bear a disproportionate share of the caregiving burden, note that progress towards gender equality and the empowerment of all women and girls has been unacceptably slow and that the ability of women and girls to protect themselves from HIV continues to be compromised by physiological factors, gender inequalities, including unequal power relations in society between women and men, boys and girls, unequal legal, economic and social status, insufficient access to health-care services, including sexual and reproductive

health, as well as all forms of discrimination and violence in the public and private spheres, including trafficking in persons, sexual violence, exploitation and harmful practices;

61. (a) Recognize that unequal socioeconomic status of women compromises their ability to prevent HIV or mitigate the impact of AIDS and acknowledge the mutually reinforcing links between the achievement of gender equality and the empowerment of all women and girls and the eradication of poverty, reaffirm that the promotion and protection of, and respect for, the human rights and fundamental freedoms of women, should be mainstreamed into all policies and programmes aimed at the eradication of poverty;

61. (b) Stress in that regard that the lack of protection and promotion of the human rights of all women and their sexual and reproductive health and reproductive rights in accordance with the Programme of Action of the International Conference on Population and Development, the Beijing Platform for Action and the outcome documents of their review conferences, and insufficient access to the highest attainable standard of physical and mental health, aggravates the impact of the epidemic especially amongst women and girls, increasing their vulnerability and endangering the survival of present and future generations;

61. (c) Pledge to eliminate gender inequalities and gender-based abuse and violence, increase the capacity of women and adolescent girls to protect themselves from the risk of HIV infection, principally through the provision of health care and services, including, inter alia, sexual and reproductive health, as well as full access to comprehensive information and education, ensure that women can exercise their right to have control over, and decide freely and responsibly on, matters related to their sexuality, including their sexual and reproductive health, free of coercion, discrimination and violence, in order to increase their ability to protect themselves from HIV infection, and take all necessary measures to create an enabling environment for the empowerment of women and to strengthen their economic independence, and, in this context, reiterate the importance of the role of men and boys in achieving gender equality;

61. (d) Commit to achieve gender equality and the empowerment of all women and girls, to respect, promote and protect their human rights, education and health, including their sexual and reproductive health, by investing in gender-responsive approaches and ensuring gender mainstreaming at all levels, supporting women's leadership in the AIDS response, engaging men and boys, recognizing that gender equality and positive gender norms promote effective responses to HIV;

61. (h) Commit to end all forms of violence and discrimination against women and girls, such as gender-based, sexual, domestic and intimate partner violence, by i.a. eliminating sexual exploitation of women, girls and boys, trafficking in persons, femicide, abuse, rape in every and all circumstances, and other forms of sexual violence, discriminatory laws and harmful social norms that perpetuate the unequal status of women and girls, as well as harmful practices such

as child, early and forced marriage, forced pregnancy, forced sterilization, in particular of women living with HIV, forced and coerced abortion and female genital mutilation, including in conflict, post-conflict and other humanitarian emergencies, as these can have serious and long-lasting impacts on the health and well-being of women and girls throughout the lifecycle and increase their vulnerability to HIV;

61. (i) Commit to adopting, reviewing and accelerating effective implementation of laws that criminalize violence against women and girls, as well as comprehensive, multidisciplinary and gender-responsive preventive, protective and prosecutorial measures and services to eliminate and prevent all forms of violence against all women and girls, in public and private spaces, as well as harmful practices;

61. (j) Address all health consequences, including the physical, mental and sexual and reproductive health consequences, of violence against women and girls by providing accessible health-care services that are responsive to trauma and include affordable, safe, effective and good quality medicines, first line support, treatment of injuries and psychosocial and mental health support, emergency contraception, safe abortion where such services are permitted by national law, post-exposure prophylaxis for HIV infection, diagnosis and treatment for sexually transmitted infections, training for medical professionals to effectively identify and treat women subjected to violence, as well as forensic examinations by appropriately trained professionals;

61. (k) Commit to develop and to strengthen, in all countries, national policies, norms and measures directly aimed at awareness, prevention and punishment of all forms of violence and discrimination against women and girls, as well as to develop policies aimed at the prevention of sexual violence and comprehensive care for children and adolescents sexually abused;

Annex 9.2 Use of the term ‘young people’ and related terms in Political Declarations on HIV & AIDS

(a) 2001 Political Declaration

33. Acknowledging the particular role and significant contribution of people living with HIV/AIDS, young people and civil society actors in addressing the problem of HIV/AIDS in all its aspects, and recognizing that their full involvement and participation in the design, planning, implementation and evaluation of programmes is crucial to the development of effective responses to the HIV/AIDS epidemic;

37. By 2003, ensure the development and implementation of multisectoral national strategies and financing plans for combating HIV/AIDS that address the epidemic in forthright terms; confront stigma, silence and denial; address gender and age-based dimensions of the epidemic; eliminate discrimination and marginalization; involve partnerships with civil society and the business sector and the full participation of people living with HIV/AIDS, those in vulnerable groups and people mostly at risk, particularly women and young people; are resourced to the extent possible from national budgets without excluding other sources, inter alia, international cooperation; fully promote and protect all human rights and fundamental freedoms, including the right to the highest attainable standard of physical and mental health; integrate a gender perspective; address risk, vulnerability, prevention, care, treatment and support and reduction of the impact of the epidemic; and strengthen health, education and legal system capacity;

63. By 2003, develop and/or strengthen strategies, policies and programmes which recognize the importance of the family in reducing vulnerability, inter alia, in educating and guiding children and take account of cultural, religious and ethical factors, to reduce the vulnerability of children and young people by ensuring access of both girls and boys to primary and secondary education, including HIV/AIDS in curricula for adolescents; ensuring safe and secure environments, especially for young girls; expanding good-quality, youth-friendly information and sexual health education and counselling services; strengthening reproductive and sexual health programmes; and involving families and young people in planning, implementing and evaluating HIV/AIDS prevention and care programmes, to the extent possible;

(b) 2006 Political Declaration

8. Express grave concern that half of all new HIV infections occur among children and young people under the age of 25, and that there is a lack of information, skills and knowledge regarding HIV/AIDS among young people;

26. Commit ourselves to addressing the rising rates of HIV infection among young people to ensure an HIV-free future generation through the implementation of comprehensive, evidence-

based prevention strategies, *responsible sexual behaviour* including the use of condoms, evidence- and skills-based, youth-specific HIV education, mass media interventions and the provision of youth-friendly health services

(c) 2011 Political Declaration

25. Express grave concern that young people between the ages of 15 and 24 years account for more than one third of all new HIV infections, with some 3,000 young people becoming infected with HIV each day, and note that most young people still have limited access to good quality education, decent employment and recreational facilities, as well as limited access to sexual and reproductive health programmes that provide the information, skills, services and commodities they need to protect themselves that only 34 per cent of young people possess accurate knowledge of HIV, and that laws and policies in some instances exclude young people from accessing sexual health-care and HIV-related services, such as voluntary and confidential HIV-testing, counselling and age-appropriate sex and HIV prevention education, while also recognizing the importance of reducing risk taking behaviour and encouraging responsible sexual behaviour, including abstinence, fidelity and correct and consistent use of condoms;

56. Commit to encouraging and supporting the active involvement and leadership of young people, including those living with HIV, in the fight against the epidemic at the local, national and global levels, and agree to work with these new leaders to help develop specific measures to engage young people about HIV, including in communities, families, schools, tertiary institutions, recreation centres and workplaces;

59. Commit to redouble HIV prevention efforts by taking all measures to implement comprehensive, evidence-based prevention approaches, taking into account local circumstances, ethics and cultural values, including through, but not limited to:

59 (b) Harnessing the energy of young people in helping to lead global HIV awareness;

59 (e) Ensuring that all people, particularly young people, have the means to exploit the potential of new modes of connection and communication;

(d) 2016 Political Declaration

39. Express grave concern that young people between the ages of 15 and 24 years account for more than one third of all new HIV infections among adults, with 2,000 young people becoming infected with HIV each day, that AIDS-related deaths are increasing among adolescents making AIDS the second leading cause of death in adolescents globally, and note that many young people have limited access to good quality education, nutritious food, decent employment and recreational facilities, as well as limited access to sexual and reproductive health-care services

and programmes that provide the commodities, skills, knowledge and capability they need to protect themselves from HIV, that only 36 per cent of young men and 28 per cent of young women (15-24) possess accurate knowledge of HIV, and that laws and policies in some instances exclude young people from accessing sexual and reproductive health-care and HIV-related services, such as voluntary and confidential HIV testing, counselling, information and education, while also recognizing the importance of reducing risk-taking behaviour and encouraging responsible sexual behaviour, including correct and consistent use of condoms;

47. Note with grave concern that the holistic needs and human rights of people living with, at risk of, and affected by HIV, and young people, remain insufficiently addressed because of inadequate integration of health services, including sexual and reproductive health-care and HIV services, including for people who have experienced sexual or gender-based violence, including post-exposure prophylaxis, legal services and social protection;

62. (d) Commit to saturate areas with high HIV incidence with a combination of tailored prevention interventions, including outreach via traditional and social media and peer-led mechanisms, male and female condom programming, voluntary medical male circumcision, and effective measures aimed at minimizing the adverse public health and social consequences of drug abuse, including appropriate medication assisted therapy programmes, injecting equipment programmes, pre-exposure prophylaxis for people at high risk of acquiring HIV, antiretroviral therapy, and other relevant interventions that prevent the transmission of HIV with particular focus on young people, particularly young women and girls, and encourage the financial and technical support of international partners as appropriate;

62. (j) Commit to eliminate barriers, including stigma and discrimination in health-care settings, to ensure universal access to comprehensive HIV diagnostic, prevention, treatment, care and support for people living with, at risk of, and affected by HIV, persons deprived of their liberty, indigenous people, children, adolescents, young people, women, and other vulnerable populations;

63. (f) Commit to promoting laws and policies that ensure the enjoyment of all human rights and fundamental freedoms for children, adolescents and young people, particularly those living with, at risk of, and affected by HIV, so as to eliminate the stigma and discrimination they face;

64. (a) Call for increased and sustained investment in the advocacy and leadership role, involvement and empowerment of people living with, at risk of, and affected by HIV, women children, young people, especially young women and girls, local leaders, community-based organizations, indigenous communities and civil society more generally as part of a broader effort to ensure at least 6% of all global AIDS resources are allocated for social enablers including advocacy, community and political mobilization, community monitoring, public communication,

outreach programmes to increase access to rapid tests and diagnosis, as well as human rights programmes such as law and policy reform, and stigma and discrimination reduction;

64. (b) Commit to encouraging and supporting the active involvement and leadership of young people, particularly women, including those living with HIV, in the fight against the epidemic at the local, subregional, regional, national and global levels, and agree to support these new leaders to help develop specific measures to engage young people about HIV, including in communities, families, schools, tertiary institutions, recreation centres and workplaces;

Annex 9.3 Use of the word ‘vulnerable’ and related terms in Political Declarations on HIV & AIDS

(a) 2001 Political Declaration

19. Recognizing that care, support and treatment can contribute to effective prevention through an increased acceptance of voluntary and confidential counselling and testing, and by keeping people living with HIV/AIDS and vulnerable groups in close contact with health-care systems and facilitating their access to information, counselling and preventive supplies;

27. Welcoming the progress made in some countries to contain the epidemic, particularly through: strong political commitment and leadership at the highest levels, including community leadership; effective use of available resources and traditional medicines; successful prevention, care, support and treatment strategies; education and information initiatives; working in partnership with communities, civil society, people living with HIV/AIDS and vulnerable groups; and the active promotion and protection of human rights; and recognizing the importance of sharing and building on our collective and diverse experiences, through regional and international cooperation including North-South, South-South and triangular cooperation;

32. Affirming that beyond the key role played by communities, strong partnerships among Governments, the United Nations system, intergovernmental organizations, people living with HIV/AIDS and vulnerable groups, medical, scientific and educational institutions, non-governmental organizations, the business sector including generic and research-based pharmaceutical companies, trade unions, the media, parliamentarians, foundations, community organizations, faith-based organizations and traditional leaders are important;

37. By 2003, ensure the development and implementation of multisectoral national strategies and financing plans for combating HIV/AIDS that address the epidemic in forthright terms; confront stigma, silence and denial; address gender and age-based dimensions of the epidemic; eliminate discrimination and marginalization; involve partnerships with civil society and the business sector and the full participation of people living with HIV/AIDS, those in vulnerable groups and people mostly at risk, particularly women and young people; are resourced to the extent possible from national budgets without excluding other sources, inter alia, international cooperation; fully promote and protect all human rights and fundamental freedoms, including the right to the highest attainable standard of physical and mental health; integrate a gender perspective; address risk, vulnerability, prevention, care, treatment and support and reduction of the impact of the epidemic; and strengthen health, education and legal system capacity;

46. Foster stronger collaboration and the development of innovative partnerships between the public and private sectors, and by 2003 establish and strengthen mechanisms that involve the

private sector and civil society partners and people living with HIV/AIDS and <u>vulnerable groups</u> in the fight against HIV/AIDS;

48. By 2003, establish national prevention targets, recognizing and addressing factors leading to the spread of the epidemic and increasing <u>people's vulnerability</u>, to reduce HIV incidence for those identifiable groups, within particular local contexts, which currently have high or increasing rates of HIV infection, or which available public health information indicates are at the highest risk of new infection;

58. By 2003, enact, strengthen or enforce, as appropriate, legislation, regulations and other measures to eliminate all forms of discrimination against and to ensure the full enjoyment of all human rights and fundamental freedoms by people living with HIV/AIDS and members of <u>vulnerable groups</u>, in particular to ensure their access to, inter alia, education, inheritance, employment, health care, social and health services, prevention, support and treatment, information and legal protection, while respecting their privacy and confidentiality; and develop strategies to combat stigma and social exclusion connected with the epidemic;

61. By 2005, ensure development and accelerated implementation of national strategies for women's empowerment, the promotion and protection of women's full enjoyment of all human rights and reduction of their <u>vulnerability</u> to HIV/AIDS through the elimination of all forms of discrimination, as well as all forms of violence against women and girls, including harmful traditional and customary practices, abuse, rape and other forms of sexual violence, battering and trafficking in women and girls;

Under the sub heading: **Reducing vulnerability**

The <u>vulnerable</u> must be given priority in the response
Empowering women is essential for reducing <u>vulnerability</u>

62. By 2003, in order to complement prevention programmes that address activities which place individuals at risk of HIV infection, <u>such as risky and unsafe sexual behaviour and injecting drug use</u>, have in place in all countries strategies, policies and programmes that identify and begin to address those <u>factors that make individuals particularly</u> <u>vulnerable</u> to HIV infection, including underdevelopment, economic insecurity, poverty, lack of empowerment of women, lack of education, social exclusion, illiteracy, discrimination, lack of information and/or commodities for self-protection, and all types of sexual exploitation of women, girls and boys, including for commercial reasons. Such strategies, policies and programmes should address the gender dimension of the epidemic, specify the action that will be taken to address <u>vulnerability</u> and set targets for achievement;

63. By 2003, develop and/or strengthen strategies, policies and programmes which recognize the importance of the family in reducing vulnerability, inter alia, in educating and guiding children and take account of cultural, religious and ethical factors, to reduce the vulnerability of children and young people by ensuring access of both girls and boys to primary and secondary education, including HIV/AIDS in curricula for adolescents; ensuring safe and secure environments, especially for young girls; expanding good-quality, youth-friendly information and sexual health education and counselling services; strengthening reproductive and sexual health programmes; and involving families and young people in planning, implementing and evaluating HIV/AIDS prevention and care programmes, to the extent possible;

64. By 2003, develop and/or strengthen national strategies, policies and programmes, supported by regional and international initiatives, as appropriate, through a participatory approach, to promote and protect the health of those identifiable groups which currently have high or increasing rates of HIV infection or which public health information indicates are at greatest risk of and most vulnerable to new infection as indicated by such factors as the local history of the epidemic, poverty, sexual practices, drug-using behaviour, livelihood, institutional location, disrupted social structures and population movements, forced or otherwise;

(b) 2006 Political Declaration

2. Note with alarm that we are facing an unprecedented human catastrophe; that a quarter of a century into the pandemic, AIDS has inflicted immense suffering on countries and communities throughout the world; and that more than 65 million people have been infected with HIV, more than 25 million people have died of AIDS, 15 million children have been orphaned by AIDS and millions more made vulnerable, and 40 million people are currently living with HIV, more than 95 per cent of whom live in developing countries;

7. Remain deeply concerned, however, by the overall expansion and feminization of the pandemic and the fact that women now represent 50 per cent of people living with HIV worldwide and nearly 60 per cent of people living with HIV in Africa, and in this regard recognize that gender inequalities and all forms of violence against women and girls increase their vulnerability to HIV/AIDS;

14. Recognize also that we now have the means to reverse the global pandemic and to avert millions of needless deaths, and that to be effective, we must deliver an intensified, much more urgent and comprehensive response, in partnership with the United Nations system, intergovernmental organizations, people living with HIV and vulnerable groups, medical, scientific and educational institutions, non-governmental organizations, the business sector, including generic and research-based pharmaceutical companies, trade unions, the media, parliamentarians, foundations, community organizations, faith-based organizations and traditional leaders;

15. Recognize further that to mount a comprehensive response, we must overcome any legal, regulatory, trade and other barriers that block access to prevention, treatment, care and support; commit adequate resources; promote and protect all human rights and fundamental freedoms for all; promote gender equality and empowerment of women; promote and protect the rights of the girl child in order to reduce the vulnerability of the girl child to HIV/AIDS; strengthen health systems and support health workers; support greater involvement of people living with HIV; scale up the use of known effective and comprehensive prevention interventions; do everything necessary to ensure access to life-saving drugs and prevention tools; and develop with equal urgency better tools – drugs, diagnostics and prevention technologies, including vaccines and microbicides – for the future;

16. Convinced that without renewed political will, strong leadership and sustained commitment and concerted efforts on the part of all stakeholders at all levels, including people living with HIV, civil society and vulnerable groups, and without increased resources, the world will not succeed in bringing about the end of the pandemic;

20. Commit ourselves to pursuing all necessary efforts to scale up nationally driven, sustainable and comprehensive responses to achieve broad multisectoral coverage for prevention, treatment, care and support, with full and active participation of people living with HIV, vulnerable groups, most affected communities, civil society and the private sector, towards the goal of universal access to comprehensive prevention programmes, treatment, care and support by 2010;

29. Commit ourselves to intensifying efforts to enact, strengthen or enforce, as appropriate, legislation, regulations and other measures to eliminate all forms of discrimination against and to ensure the full enjoyment of all human rights and fundamental freedoms by people living with HIV and members of vulnerable groups, in particular to ensure their access to, inter alia, education, inheritance, employment, health care, social and health services, prevention, support and treatment, information and legal protection, while respecting their privacy and confidentiality; and developing strategies to combat stigma and social exclusion connected with the epidemic

31. Commit ourselves to strengthening legal, policy, administrative and other measures for the promotion and protection of women's full enjoyment of all human rights and the reduction of their vulnerability to HIV/AIDS through the elimination of all forms of discrimination, as well as all types of sexual exploitation of women, girls and boys, including for commercial reasons, and all forms of violence against women and girls, including harmful traditional and customary practices, abuse, rape and other forms of sexual violence, battering and trafficking in women and girls;

32. Commit ourselves also to addressing as a priority the vulnerabilities faced by children affected by and living with HIV; providing support and rehabilitation to these children and their families, women and the elderly, particularly in their role as caregivers; promoting child-oriented HIV/AIDS policies and programmes and increased protection for children orphaned and affected by HIV/AIDS; ensuring access to treatment and intensifying efforts to develop new treatments for children; and building, where needed, and supporting the social security systems that protect them;

34. Commit ourselves to expanding to the greatest extent possible, supported by international cooperation and partnership, our capacity to deliver comprehensive HIV/AIDS programmes in ways that strengthen existing national health and social systems, including by integrating HIV/AIDS intervention into programmes for primary health care, mother and child health, sexual and reproductive health, tuberculosis, hepatitis C, sexually transmitted infections, nutrition, children affected, orphaned or made vulnerable by HIV/AIDS, as well as formal and informal education;

51. Call upon Governments, national parliaments, donors, regional and subregional organizations, organizations of the United Nations system, the Global Fund to Fight AIDS, Tuberculosis and Malaria, civil society, people living with HIV, vulnerable groups, the private sector, communities most affected by HIV/AIDS and other stakeholders to work closely together to achieve the targets set out above, and to ensure accountability and transparency at all levels through participatory reviews of responses to HIV/AIDS;

(c) 2011 Political Declaration

4. Recognize that although HIV and AIDS are affecting every region of the world, each country's epidemic is distinctive in terms of drivers, vulnerabilities, aggravating factors and the populations that are affected, and therefore the responses from both the international community and the countries themselves must be uniquely tailored to each particular situation taking into account the epidemiological and social context of each country concerned;

27. Recall our commitment that prevention must be the cornerstone of the global HIV and AIDS response, but note that many national HIV prevention programmes and spending priorities do not adequately reflect this commitment, that spending on HIV prevention is insufficient to mount a vigorous, effective and comprehensive global HIV prevention response, that national prevention programmes are often not sufficiently coordinated and evidence-based, that prevention strategies do not adequately reflect infection patterns or sufficiently focus on populations at higher risk of HIV, and that only 33 per cent of countries have prevalence targets for young people and only 34 per cent have specific goals in place for condom programming;

43. Reaffirm the central role of the family, bearing in mind that in different cultural, social and political systems various forms of the family exist, in reducing vulnerability to HIV, inter alia in educating and guiding children, and take account of cultural, religious and ethical factors in reducing the vulnerability of children and young people by ensuring access of both girls and boys to primary and secondary education, including HIV and AIDS in curricula for adolescents, ensuring safe and secure environments especially for young girls, expanding good-quality youth friendly information and sexual health education and counselling services, strengthening reproductive and sexual health programmes, and involving families and young people in planning, implementing and evaluating HIV and AIDS prevention and care programmes, to the extent possible;

82. Commit to strengthen national social and child protection systems and care and support programmes for children, in particular for the girl child, and adolescents affected by and vulnerable to HIV, as well as their families and caregivers, including through the provision of equal opportunities to support the development to full potential of orphans and other children affected by and living with HIV, especially through equal access to education, the creation of safe and non-discriminatory learning environments, supportive legal systems and protections, including civil registration systems, and provision of comprehensive information and support to children and their families and caregivers, especially age-appropriate HIV information to assist children living with HIV as they transition through adolescence, consistent with their evolving capacities;

84. Commit to address, according to national legislation, the vulnerabilities to HIV experienced by migrant and mobile populations and support their access to HIV prevention, treatment, care and support;

(d) 2016 Political Declaration

14. Emphasize the continued importance, particularly given the 2015 World Health Organization Guidelines recommending that antiretroviral therapy be initiated for everyone living with HIV at any CD4 cell count, of a more integrated and systemic approach to addressing people's access to quality, people-centred health-care services in a more holistic manner, in the context of promoting the right to the enjoyment of the highest attainable standard of physical and mental health and well-being, universal access to sexual and reproductive health and reproductive rights in accordance with the Programme of Action of the International Conference on Population and Development and the Beijing Platform for Action and the outcome documents of their review conferences, universal health coverage, social protection for people in vulnerable situations, local, national and international health and social protection systems strengthening, including community systems, integrated responses to address non-communicable diseases and HIV and AIDS, and preparedness to tackle emerging disease outbreaks, such as Ebola, Zika and those yet to be identified, and other health threats;

15. Emphasize that to guarantee the sustainability of HIV prevention, treatment, care, and support services, information and education, which are mutually reinforcing, these should be integrated with national health systems and services to address coinfections and co-morbidities, in particular tuberculosis, substance use and mental disorders, as well as sexual and reproductive health-care services, including prevention, screening and treatment for viral hepatitis and cervical cancer, as well as other sexually transmitted infections, including human papillomavirus, and services to respond to sexual and gender-based violence while noting the particular vulnerability of women and girls to these coinfections and co-morbidities;

45. Note with grave concern that, despite the recognition of the need to promote, protect and fulfil the human rights and fundamental freedoms of persons with disabilities including as set forth in the Convention on the Rights of Persons with Disabilities and despite the increased vulnerability to HIV infection faced by women and girls living with disabilities resulting from, inter alia, legal and economic inequalities, sexual and gender-based violence, discrimination and violations of their human rights, the formulation of the global AIDS response remains inadequately targeted and accessible to persons with disabilities;

49. Recognize that each country faces specific challenges to achieve sustainable development, and we underscore the special challenges facing the most vulnerable countries and, in particular, African countries, least developed countries, landlocked developing countries and small island developing States, as well as the specific challenges facing the middle-income countries, and note that countries in situations of conflict also need special attention;

57. Commit to differentiate AIDS responses, based on country ownership and leadership, local priorities, drivers, vulnerabilities, aggravating factors, the populations that are affected and strategic information and evidence, and to set ambitious quantitative targets, where appropriate depending on epidemiological and social context, tailored to national circumstances in support of these goals;

59. (g) Recognize that international public finance plays an important role in complementing efforts of countries to mobilize public resources domestically, especially in the poorest and most vulnerable countries with limited domestic resources. Scaled up and more effective international support, including both concessional and non-concessional financing, is required;

60. (h) Commit to reduce the high rates of HIV and hepatitis B and C co-infection and ensure that by 2020, efforts are made to reduce by 30% new cases of viral hepatitis B and C infections, and have 5 million people receiving hepatitis B treatment and to have treated 3 million people with chronic hepatitis C infection, also taking into account the linkages to and lessons learnt from the AIDS response such as the promotion and protection of human rights, reduction of stigma and discrimination, community engagement, stronger integration of HIV and hepatitis B and C service

delivery, efforts towards guaranteeing access to affordable medicines and effective prevention interventions particularly for vulnerable populations and populations that epidemiological evidence shows are at higher risk of infection;

60. (n) Commit to pursuing the continuity of HIV prevention, treatment, care and support and to providing a package of care for people living with HIV, TB and/or malaria in humanitarian emergencies and conflict settings, as displaced people and people affected by humanitarian emergencies face multiple challenges, including heightened HIV vulnerability, risk of treatment interruption and limited access to quality health-care and nutritious food;

61. (b) Stress in that regard that the lack of protection and promotion of the human rights of all women and their sexual and reproductive health and reproductive rights in accordance with the Programme of Action of the International Conference on Population and Development, the Beijing Platform for Action and the outcome documents of their review conferences, and insufficient access to the highest attainable standard of physical and mental health, aggravates the impact of the epidemic especially amongst women and girls, increasing their vulnerability and endangering the survival of present and future generations;

61. (h) Commit to end all forms of violence and discrimination against women and girls, such as gender-based, sexual, domestic and intimate partner violence, by i.a. eliminating sexual exploitation of women, girls and boys, trafficking in persons, femicide, abuse, rape in every and all circumstances, and other forms of sexual violence, discriminatory laws and harmful social norms that perpetuate the unequal status of women and girls, as well as harmful practices such as child, early and forced marriage, forced pregnancy, forced sterilization, in particular of women living with HIV, forced and coerced abortion and female genital mutilation, including in conflict, post-conflict and other humanitarian emergencies, as these can have serious and long-lasting impacts on the health and well-being of women and girls throughout the lifecycle and increase their vulnerability to HIV;

Annex 9.4: Critical Frame Analysis comparing four paragraphs in PD2011 on women, using Verloo methodology

(a) Paragraphs 21 & 53

21. Remain deeply concerned that globally women and girls are still the most affected by the epidemic and that they bear a disproportionate share of the caregiving burden, and that the ability of women and girls to protect themselves from HIV continues to be compromised by physiological factors, gender inequalities, including unequal legal, economic and social status, insufficient access to health care and services, including for sexual and reproductive health, and all forms of discrimination and violence, including sexual violence and exploitation against them;

53. Pledge to eliminate gender inequalities and gender-based abuse and violence, increase the capacity of women and adolescent girls to protect themselves from the risk of HIV infection, principally through the provision of health care and services, including, inter alia, sexual and reproductive health, as well as full access to comprehensive information and education, ensure that women can exercise their right to have control over, and decide freely and responsibly on, matters related to their sexuality in order to increase their ability to protect themselves from HIV infection, including their sexual and reproductive health, free of coercion, discrimination and violence, and take all necessary measures to create an enabling environment for the empowerment of women and strengthen their economic independence, and, in this context, reiterate the importance of the role of men and boys in achieving gender equality;

Critical Frame Analysis

Who has voice in the text?	MS are the authors, policy makers and duty bearers, not the women themselves. Correspondingly, it is MS who make the pledge to take responsibility and action. The action however lacks clarity-it does not spell out what MS will do to ensure that women can exercise their rights, or what the 'necessary measures' are to create an enabling environment for empowerment
Diagnosis • What is represented as the problem? • Why is it seen as a problem?	When PD2011, 21 and 53 are interrogated using these questions, the problems emerge as follows: women and girls are more affected by HIV; bear a disproportionate share of the care-giving burden; lack the capacity to protect themselves from HIV infection; lack the ability to exercise their right to control in matters relating to sexual and reproductive health without coercion, discrimination and violence; are subject to unequal legal, economic and social status, sexual violence and exploitation; and lack access to healthcare services, including information and education (General Assembly Resolution 2011, 21 ,53). Reasons given for these problems include: that women are compromised and unable to protect themselves; they are unable

	to decide freely and responsibly, free from coercion, discrimination and violence; they do not have economic independence, legal equity and adequate access to information, education and healthcare services (General Assembly Resolution 2011, 21 ,53).
Dimensions of gender • Social categories, identity, behaviour, norms, symbols and institutions	Traditional gender norms in terms of women's and girls' identity, characteristics, social position and expected behaviours are all affirmed through this framing and match those of the traditional religio-cultural discourse. These norms are legitimized rather than challenged through the framing. Women's care-giving role is not challenged; rather its disproportionate size is considered a source of 'deep concern'. However, no action is proposed to address this.
Attribution of roles in diagnosis • Causality - who is seen to have made the problem? • Responsibility - who is seen as responsible for the problem? • Problem holders - whose problem is it seen to be? • Normativity -what is a norm group if there is a problem group? • Active & passive roles - perpetrators, victims, etc • Legitimisation of non-problem(s)	Responsibility. Women have the responsibility for care giving. Active/passive roles: Perpetrators of violence are men and boys, victims are women and girls (implied) The state is also implicated in that it did not provide for equal legal and economic status for women and girls, nor did it provide health services- including sexual and reproductive health services equally accessible to men and women Violence is not legitimized; rather it is viewed as something to be eliminated. The discussion of sexual violence does however legitimize the passive nature of women as victims of unequal social, legal and economic structures in society, of discrimination, of violence and exploitation.
Prognosis • What to do? • Hierarchy, priority in goals • How to achieve goals – strategy, means, instruments? • Dimensions of gender - Social categories, identity, behaviour, norms, symbols and institutions • Intersectionality • Mechanisms – resources, norms and interpretations, violence • Form – argumentation, style, conviction technique, dichotomies, metaphors) • Location - organisation of labour, intimacy • Citizenship	The solutions proposed by MS in PD2011, 53 include: to eliminate gender inequalities, principally through the provision of health care services and access to comprehensive information and education No data or evidence are presented to support the 'deep concern' however- there is no attempt to quantify the problem. PD2011, 21 does not use a rights-based approach to challenge the passive projection of women as victims, nor does it specify how to provide women with agency to address these deep concerns. To ensure women can exercise their right to have control over- and decide responsibly…the solution proposed is to strengthen economic independence- but no proposals are included on how to achieve this. The primary role to achieve gender equality is given to men and boys, who by implication are the perpetrators of violence Women and girls are responsible for protecting themselves from infection and exercising their rights. The legal system is unequal. The economic system is unequal. The health care system is unequally available. The argumentation style in PD2011, 21 expresses formal concern-

	but does not take responsibility or condemn the violence or inequities, rather accepts them as the status quo. Nor does is specify the actions that MS should take to address these problems and inequalities There are no apparent dichotomies metaphors or contrasts in the text of PD2011, 21.
Attribution of roles in prognosis • Call for action and non-action - who should [not] do what? • Who has voice in suggesting suitable course of action? • Who is acted upon? (target groups) • Boundaries set to action • Legitimisation of (non)action	MS have voice in suggesting actions- but actions suggested are framed in terms of enabling women to protect themselves from HIV as opposed to MS taking responsibility to address the factors which put them at risk. In PD2011, 53, presumably the health service is acted upon. No indication is given as to how an enabling environment for empowerment and economic independence will be achieved.
Normativity • What is seen as good? • What is seen as bad? • Location of norms in the text – diagnosis, prognosis, elsewhere	Women are most affected by the epidemic and are unable to protect themselves from infection because of circumstances, violence and exploitation of them. This is seen as bad. By implication the norm group is men- and the problem group women and girls

(b) Paragraphs 41 & 81

41. Recognize that access to sexual and reproductive health has been and continues to be essential for HIV and AIDS responses, and that Governments have the responsibility to provide for public health, with special attention to families, women and children;

81. Commit to ensuring that national responses to HIV and AIDS meet the specific needs of women and girls, including those living with and affected by HIV, across their lifespan, through strengthening legal, policy, administrative and other measures for the promotion and protection of women's full enjoyment of all human rights and the reduction of their vulnerability to HIV through the elimination of all forms of discrimination, as well as all types of sexual exploitation of women, girls and boys, including for commercial reasons, and all forms of violence against women and girls, including harmful traditional and customary practices, abuse, rape and other forms of sexual violence, battering and trafficking in women and girls;

Critical Frame Analysis

Who has voice in the text?	The primary actor is the state, who has the voice in the document and has the responsibility to provide public health services for women and children

	MS in this paragraph commit to ensure that 'national responses to HIV and AIDS meet the specific needs of women and girls, including those living with and affected by HIV, across their lifespan'(General Assembly Resolution 2011, 81)
Diagnosis • What is represented as the problem? • Why is it seen as a problem?	In PD2011, 41, the central concept is that sexual and reproductive health services are essential for the HIV response P81- by implication- national responses to HIV and AIDS do not meet the specific needs of women and girls, including those living with and affected by HIV, across their lifespan
Dimensions of gender • Social categories, identity, behaviour, norms, symbols and institutions	While no data is presented to support the case for women and girls in 2011 Women and children are not framed as passive victims, but as the rightful beneficiaries of services, as citizens (General Assembly Resolution 2011, 41)
Attribution of roles in diagnosis • Causality - who is seen to have made the problem? • Responsibility - who is seen as responsible for the problem? • Problem holders - whose problem is it seen to be? • Normativity -what is a norm group if there is a problem group? • Active/passive roles – perpetrators, victims, etc • Legitimisation of non-problem(s)	The government as responsible to provide sexual and reproductive health services Active role assigned to the government with the responsibility to provide services. In PD2011,41 violence is not legitimized, neither is a passive or traditional framing of women. Families women and children are identified as rightful beneficiaries.
Prognosis • What to do? • Hierarchy, priority in goals • How to achieve goals – strategy, means, instruments? • Dimensions of gender - Social categories, identity, behaviour, norms, symbols and institutions • Intersectionality • Mechanisms – resources, norms and interpretations, violence • Form – argumentation, style, conviction technique, dichotomies, metaphors) • Location - organisation of labour, intimacy • Citizenship	MS commit to ensuring that national HIV responses meet the needs of women and girls. MS commit to eliminate discrimination, 'as well as all types of sexual exploitation of women, girls and boys, including for commercial reasons, and all forms of violence against women and girls, (General Assembly Resolution 2011, 81). Goals are to be achieved through strengthening legal, policy, administrative and other measures for the promotion and protection of women's full enjoyment of all human rights. The argumentation style is factual and proactive; recognize the problem, recognize who is responsible, identify the solution, no assignment of providing the solution to the citizens themselves.

Attribution of roles in prognosis • Call for action and non-action - who should [not] do what? • Who has voice in suggesting suitable course of action? • Who is acted upon? (target groups) • Boundaries set to action • Legitimisation of (non)action	MS have voice in suggesting actions The commitment by MS is to address the national legal, policy and other frameworks, to act as the duty bearer. To promote and protect human rights
Normativity • What is seen as good? • What is seen as bad? • Location of norms in the text – diagnosis, prognosis, elsewhere	These two paragraphs 41 and 81 give a very different picture to PS2011 21 and 53. The good/bad dichotomy is less obvious. By implication all forms of discrimination, as well as all types of sexual exploitation of women, girls and boys, including for commercial reasons, and all forms of violence against women and girls, including harmful traditional and customary practices, abuse, rape and other forms of sexual violence, battering and trafficking in women and girls are bad

The analysis of PD2011 21 and 53 demonstrate that the State as author and policy maker of this document is the player with voice, not the individual. The role played by the state is characteristic of early approaches to stigma and discrimination described by Parker and Aggleton, where negative attributes are mapped onto individuals. (Parker and Aggleton 2003, 14)

In PD2011 41 and 81 MS address the structural drivers of vulnerability such as policy and laws. These paragraphs are characteristic of a human rights and gender equality discourse, and in line with the conceptual framework put forward by Parker and Aggleton that advocates a rights-based approach in which discrimination is seen as a breach of the state's obligation to protect the rights of citizens (Parker and Aggleton 2003, 21)

Annex 10: Analysis of the negotiations on wording from zero text to final draft – selected controversial paragraphs from PD 2011

(a) Paragraph 25

Zero Draft Paragraph number and text	13. Express grave concern that young people of ages 15 to 24 account for 35 per cent of all new infections, with some 3000 young people becoming infected with HIV each day; yet most young people still have little or no access to sexual and reproductive health programmes that provide the information, skills, services, commodities and social support they need to protect themselves from HIV infection with only 34 per cent of young people possessing accurate knowledge of HIV; and that many laws and policies exclude young people from accessing sexual health and HIV-related services such as HIV testing, counselling, provision of condoms and appropriate sexuality and HIV prevention education; while also recognizing the importance of encouraging responsible sexual behaviour, including abstinence and fidelity;
Final Draft Paragraph number and text	25. Express grave concern that young people between the ages of 15 and 24 years account for more than one third of all new HIV infections, with some 3,000 young people becoming infected with HIV each day, and note that most young people still have limited access to good quality education, decent employment and recreational facilities, as well as limited access to sexual and reproductive health programmes that provide the information, skills, services and commodities they need to protect themselves that only 34 per cent of young people possess accurate knowledge of HIV, and that laws and policies in some instances exclude young people from accessing sexual health-care and HIV-related services, such as voluntary and confidential HIV-testing, counselling and age-appropriate sex and HIV prevention education, while also recognizing the importance of reducing risk taking behaviour and encouraging responsible sexual behaviour, including abstinence, fidelity and correct and consistent use of condoms;
Strengthened-Weakened or of equal strength	Weakened a little- but given the strength of some of these statements, it is surprising that so much of the original text survived: sexuality education changed to sex and HIV prevention education. The religio-cultural rider (responsible sexual behaviour was in the original and abstinence fidelity)/ condoms moved from being provided- to education about correct and consistent use provided.
Member State Proposals	Concerns were expressed about sensitive phases such as 'access to quality education and health care services- including sexual and reproductive health care'. Some countries did not want to mention laws around young people; others wanted to introduce comprehensive and age appropriate sexuality education, others preferred HIV and prevention education. As a result of this discussion phrases around the important role of culture, family ethical and religious values were raised. The concerns about drug use in young people, which resulted in paragraph 26 being added were also discussed during negotiations along with this paragraph initially, which explains why it includes the statement about drug use being a threat to young people, children and families.
Holy See Statements-Meeting coverage (United Nations 2011b)	Support for the families and the new drug paragraph 26. However, the reference to "young people" did not enjoy international consensus. The international community must respect parents' right to provide appropriate guidance to their children, which included the primary responsibility to raise their children as they wished. States must

	acknowledge that the family based on marriage was indispensable for the fight against HIV and AIDS. It was the family that taught children moral values, and it was there that care, and support was provided.
Member State statements – Meeting coverage (United Nations 2011b).	Finland: comprehensive formal and informal sexuality education was offered from an early age, and the country was moving from a "biological" focus to a wider perspective that included emotional and social aspects. The results of that approach had been seen in a reduction in the number of teenage pregnancies and sexually transmitted infections and abortions. Young people were also delaying sexual activity. Representatives of other developed countries with a low HIV prevalence stressed the need for increased action and innovative strategies, including those involving youth, which accounted for 40 per cent of people newly infected with the disease. Germany's representative said young people must be allowed to take strong leadership roles in reducing infection. Finland's representative said they could be positive agents of change if given proper access to comprehensive sexuality education, and sexual and reproductive health services.
UNAIDS strategy language (UNAIDS 2011c)	Most young people still have inadequate access to high-quality health services, including sexual and reproductive health and rights programmes, HIV testing and condom provision. Effective school-based sexuality education is still not available in most countries (UNAIDS 2011c, 29, 30). In many societies, attitudes and laws stifle public discussion of sexuality—for example, in relation to condom use, abortion and sexual diversity. Yet whether the HIV epidemic is generalized or concentrated, the most severely affected population groups include young people. Because their youth compounds other vulnerabilities, young women and men need additional information, services and social support. Engage with networks of young people to disseminate prevention messages and support education programmes that allow young people to understand and exercise their rights to information and to services. It is critical that we empower and facilitate young people as change agents in activating their communities to redress harmful social norms governing sexuality, gender roles and other behaviour.

(b) Paragraph 26

Zero Draft Paragraph number and text	Absent from Zero Draft
Final Draft Paragraph number and text	26. Note with alarm the rise in the incidence of HIV among people who inject drugs and that, despite continuing increased efforts by all relevant stakeholders, the drug problem continues to constitute a serious threat to, among other things, public health and safety and the well-being of humanity, in particular children and young people and their families, and recognize that much more needs to be done to effectively combat the world drug problem;
Strengthened-Weakened or of equal strength	
Member State Proposals	As above- the idea for this paragraph came from discussions during negotiations of HIV risk and vulnerability among young people- language around the dangers of injecting drug use to young people grew out of this discussion
Holy See Statements- Meeting coverage (United Nations 2011b)	Holy See- Supportive of this text.
Member State statements – Meeting coverage (United Nations 2011b).	Israel: As a low-burden country for HIV, Israel had increased incidence among specific risk groups, namely its 220,000 migrant workers and men who had sex with men. To further its prevention efforts, Israel carried out national research-based AIDS prevention campaigns that emphasized condom-use and testing focused on young people and drug users. Israel also applied harm-reduction methods and ran a nationwide syringe exchange project. Universal access to HIV/AIDS screening was also necessary and should take into account the needs and practices of local cultures. Czech Republic: said the fight against HIV/AIDS could only be sustainable if it targeted the most at-risk populations, which included drug users, men who had sex with men, and sex worker, as well as geographic areas most affected by the pandemic. Efforts must be linked to the development of strong health systems. For injecting-drug users, the most affected group in the country, there was a need for universal access to harm-reduction strategies. Italy: in October 2010, had approved a national anti-drug action plan, which recognized that drug addiction was a preventable, treatable and curable disease and that the health of drug users should be protected by a “continuum of care” aimed at the individual’s full recovery and the prevention of drug-related diseases such as HIV, hepatitis and tuberculosis. If applied in isolation and outside a medical context that was focused on treatment, rehabilitation, reintegration and recovery, such harm-reduction strategies would not bear full results over the long-term. Thus, the additional concept of “risk reduction”, which was more directly linked to preventing HIV, must be applied. (Note: these interventions from countries one might expect to have a strongly conservative religious position adopt a risk reduction approach to drug use.)
UNAIDS strategy	Focus on countries that have a large number of people who inject drugs

language (UNAIDS 2011c)	(more than 100 000) coupled with a high prevalence of HIV among this population (exceeding 10%): Target: All new HIV infections prevented among people who use drugs (23). Social norms around drug use and sexual behaviour can often lead service providers to overlook or actively discourage HIV help-seeking by young people (38). Countries with punitive laws and practices around HIV transmission, sex work, drug use or homosexuality that block effective responses reduced by half (40) (Note: this language is more factual than the language adopted in the PD, which is fear-based language)

(c) Paragraph 16

Zero Draft Paragraph number and text	16. Note with concern that many national prevention strategies ignore or inadequately focus on three populations that are at higher risk of HIV infection, specifically men who have sex with men, people who inject drugs and sex workers and their clients and, accordingly, that many people from these populations find it difficult or impossible to access HIV services;
Final Draft Paragraph number and text	29. Note that many national HIV prevention strategies inadequately focus on populations that epidemiological evidence shows are at higher risk, specifically men who have sex with men, people who inject drugs and sex workers, and further note, however, that each country should define the specific populations that are key to its epidemic and response, based on the epidemiological and national context;
Strengthened-Weakened or of equal strength	Strengthening phrase added: focus on populations that epidemiological evidence shows are at higher risk. Weakened and hamstrung paragraph. 'Ignore' removed in relation to ignoring three key populations. 'Clients' of sex workers removed. 'Many people from these populations find it difficult or impossible to access HIV services' removed. Qualifying rider added: each country should define the specific populations that are key to its epidemic and response, based on the epidemiological and national context.
Member State Proposals	
Holy See Statements- Meeting coverage (United Nations 2011b)	Remove sex workers and replace with prostitutes. The Holy See rejected references to terms such as "populations at high risk" since those references treated persons as objects and gave the impression that some types of behaviour was morally acceptable. The Holy See also rejected the characterization in the text of persons who engaged in prostitution as that gave the impression that prostitution could be a legitimate form of work. Governments and society must not accept such a dehumanization and objectification of persons. What was needed was a value-based approach to counter the disease of HIV and AIDS, which provided the necessary care and moral support for those infected and promoted living in conformity with the norms of the natural moral order, respecting fully the inherent dignity of the human person.
Member State statements - Meeting coverage (United Nations 2011b).	Syria's representative, speaking on behalf of the Arab Group, voiced his "complete rejection" of the inclusion of certain groups among the list of populations considered to be the most vulnerable, saying that all groups should be treated equally and that none should be put above others. Similarly Iran's representative said the "overly targeted" document — particularly paragraph 29, which noted that many national HIV prevention strategies inadequately focused on higher risk populations, including men having sex with other men, drug users and sex workers — failed to recognize the detrimental role of risky and unethical behaviours in the spreading of the disease. Brazil's representative described the inclusion of references to those groups as "far-reaching achievements", lauding such groups for their important role in developing policies to fight the epidemic. In addition, it was important that, for the first time, targets had been set on reducing mother-to-child transmission and achieving access to antiretroviral drugs. Nepal: The multi-stakeholder response targeted the most vulnerable populations, including intravenous drug users, men having sex with men,

	migrant labourers and clients of female sex workers
UNAIDS strategy language (UNAIDS 2011c)	UNAIDS will support the attainment of these goals, including by: (1) generating commitment to prevention throughout society by improving its political palatability; (2) ensuring that strategic information on epidemics, socioeconomic drivers and responses serves to focus prevention efforts where they will deliver the greatest returns to investment; (3) incorporating new technologies and approaches as they are developed; and (4) facilitating mass mobilization for transforming social norms to empower people to overcome stigma and discrimination and their risk of HIV infection, including through comprehensive sexuality education and the engagement of networks of people living with HIV and other key populations.

(d) Paragraph 43

Zero Draft Paragraph number and text	Not included in zero draft.
Final Draft Paragraph number and text	43. Reaffirm the central role of the family, bearing in mind that in different cultural, social and political systems various forms of the family exist, in reducing vulnerability to HIV, inter alia in educating and guiding children, and take account of cultural, religious and ethical factors in reducing the vulnerability of children and young people by ensuring access of both girls and boys to primary and secondary education, including HIV and AIDS in curricula for adolescents, ensuring safe and secure environments especially for young girls, expanding good-quality youth friendly information and sexual health education and counselling services, strengthening reproductive and sexual health programmes, and involving families and young people in planning, implementing and evaluating HIV and AIDS prevention and care programmes, to the extent possible;
Strengthened-Weakened or of equal strength	The second half of para 43-is difficult to analyse. it is not clear how much of the text refers to the role of family in the direct delivery of services- and how much they should be drawn into planning, implementing and evaluating national services.
Member State Proposals	The origin of this language seems to appear in the discussions around para 39 on the full realization of Human Rights, with discussions about Government's responsibility to provide sexual and reproductive health services, draft language also included parts of what is now para 42 on the role of people living with HIV in delivering services.
Holy See Statements-Meeting coverage (United Nations 2011b)	Holy See, said that, through its approximately 117,000 health-care facilities around the world, the Catholic Church alone provided more than 25 per cent of all care for those living with HIV and AIDS, especially children. Those Church-affiliated institutions were at the forefront of providing a response that viewed people with dignity and worth as brothers and sisters and neighbours of the same human family, rather than as statistics. There was a growing international consensus that abstinence and fidelity-based programmes in parts of Africa had been successful in reducing HIV infection, where transmission had largely occurred within the general population. There were observable signs that more young people were delaying their first sexual activity and increasingly using condoms when they finally engaged. Deliberate efforts were directed at persons affected by HIV and AIDS who were in prison settings. A greater number of people living with the disease, including young people and women, were now involved in fighting it. Recognizing the value of a concerted, multisectoral, decentralized and a rights-based approach to the epidemic, Zambia had adopted a civil-society framework that was meant to build, direct and realign the capacities of all organizations involved in the fight.
Member State statements – Meeting coverage (United Nations 2011b).	Uganda supported the African Union's position on implementing programmes in line with national laws and due respect for religious and ethical values. Bahrain was less affected than other countries, perhaps because of a social system that was based on religious concerns and the family. Syria, on behalf of the Arab Group, said that Group's member States had adopted measures to facilitate the integration into their societies of people living with HIV/AIDS. Those measures were based on those

	countries' cultural, religious and moral values and had led to reductions of HIV incidence. That, he stressed, demonstrated their effectiveness, which was based on its firmest conviction — of the importance of the role of family in society and of moral, cultural and religious values in preventing the spread of HIV/AIDS and in raising the awareness of younger generations of that scourge. He reasserted the sovereign right of all States, as enshrined in the United Nations Charter and international law, regarding the implementation of programmes aimed at curbing HIV and AIDS. He added that such implementation must occur in a manner that respected the cultural and religious beliefs of a State's peoples, as well as its national legislation. He further emphasized the principles of respect and mutual understanding among Member States, taking into account their religious and cultural values. Iran also was not committed to those parts of the Declaration that might in one way or another be interpreted as promoting unethical behaviour that ran counter to the religious beliefs and cultural values of Iranian society.
UNAIDS strategy language (UNAIDS 2011c)	Evidence is mounting that comprehensive sexuality education empowers young people to make informed decisions regarding their sexual health and behaviour while playing a part in combating damaging beliefs and misconceptions about HIV and sexual health. Family-centred approaches recognize that social norms are set at the family and community level and that parents, other kin and community leaders can have a defining impact on the aspirations and choices of young people. UNAIDS Supports work with families, communities and faith-based organizations and strengthen community and social welfare systems to ensure continuous access to treatment and supplies for vulnerable and socially excluded populations—and to recognize and support caregivers.

(e) Paragraph 59

Zero Draft Paragraph number and text	40. Pledge to transform and substantially scale up HIV prevention programmes to ensure that all people are empowered with information and resources to protect themselves and others from HIV infection; ensuring that an enabling social, political and legal environment is in place to support evidence-informed prevention; exploit the potential of new modes of connection and communication; and by harnessing the energy of young people to lead global HIV awareness; 42. Commit to utilizing proven prevention approaches, including access to essential commodities, including male and female condom provision, condoms and sterile injecting equipment, targeted HIV education to raise public awareness about HIV, comprehensive harm reduction and drug dependency programs, male circumcision in certain contexts, earlier access to HIV treatment to reduce transmission as well as other prevention services for people living with HIV and the deployment of new biomedical interventions as soon as they are validated, including microbicides and HIV treatment prophylaxis;
Final Draft Paragraph number and text	59. Commit to redouble HIV prevention efforts by taking all measures to implement comprehensive, evidence-based prevention approaches, taking into account local circumstances, ethics and cultural values, including through, but not limited to: (a) Conducting public awareness campaigns and targeted HIV education to raise public awareness about HIV; (b) Harnessing the energy of young people in helping to lead global HIV awareness; (c) Reducing risk-taking behaviour and encouraging responsible sexual behaviour including abstinence, fidelity and consistent and correct use of condoms; (d) Expanding access to essential commodities, particularly male and female condoms and sterile injecting equipment; (e) Ensuring that all people, particularly young people, have the means to exploit the potential of new modes of connection and communication; (f) Significantly expanding and promoting voluntary and confidential HIV testing and counselling and provider-initiated HIV testing and counselling; (g) Intensifying national testing promotion campaigns for HIV and other sexually transmitted infections; (h) Giving consideration, as appropriate, to implementing and expanding risk and harm reduction programmes, taking into account the WHO, UNODC, UNAIDS Technical Guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users in accordance with national legislation; (i) Promoting medical male circumcision where HIV prevalence is high and male circumcision rates are low; (j) Sensitizing and encouraging the active engagement of men and boys in promoting gender equality; (k) Facilitating access to sexual and reproductive health-care services; (l) Ensuring that women of child-bearing age have access to HIV prevention-related services and that pregnant women have access to antenatal care, information, counselling and other HIV services, and increasing the availability of and access to effective treatment for women living with HIV and infants; (m) Strengthening evidence-based health sector prevention interventions, including in rural and hard to reach places; (n) Deploying new biomedical interventions as soon as they are validated, including female-initiated prevention methods such as microbicides, HIV treatment prophylaxis, earlier treatment as prevention, and an HIV vaccine;

Strengthened- Weakened or of equal strength	Paragraph 59 and it's sub-bullets has its origins in paragraphs 40- 42 of the zero draft. The initial of framing paragraph 59 is considerably weaker than paragraph 40 of the zero draft text, and is hamstrung by a limiting qualifier- 'taking into account local circumstances, ethics and cultural values'. Most of the sub-bullets in the zero draft survived the negotiation process. WHO, UNODC, UNAIDS Technical guide for countries to set targets for universal access to HIV prevention and care for injecting drug users- mentioned in 59 (h) to be considered as appropriate- in accordance with National legislation (limiting qualifiers)
Member State Proposals	A number of elements were included and subsequently deleted through the negotiations. The concept of rights was included and subsequently moved to the human rights section. Suggestions to strengthen blood safety were lost. Sub- bullet (h) is particularly hamstrung - starting with: Giving consideration, as appropriate to implementing and expanding risk and harm reduction programmes.... ending with- in accordance with national legislation: The resulting paragraph appears to be a vague suggestion to read the WHO guidelines and do as you please! -when contrasted with paragraphs (f) and (g) Other dichotomies include strengthening evidence-based health sector prevention interventions and then a focus on rural locations - when the majority of infections occurred in urban settings in 2011. The pressure to include respect for local settings is significant in this section
Holy See Statements- Meeting coverage (United Nations 2011b)	The Holy See did not accept so-called "harm reduction", and efforts related to drug abuse, as such an approach did not respect the dignity of those suffering from drug addiction, as it only falsely suggested that they could not break free from the cycle of addiction. Such persons must be provided with the necessary spiritual and psychological support to restore dignity and encourage social inclusion. Holy See is against paragraphs mentioning access to sexual and reproductive health services and education. The Holy See did not promote the use of condoms in sexual education and HIV prevention. Efforts should focus, not on trying to convince the world that dangerous behaviour formed part of an acceptable lifestyle, but on risk-avoidance that was ethically and empirically sound. The only safe and completely reliable method to prevent HIV was abstinence before marriage and respect and mutual fidelity within marriage, which was and must always be the foundation of any discussion of prevention and support. There was a growing international consensus that abstinence and fidelity-based programmes in parts of Africa had been successful in reducing HIV infection, where transmission had largely occurred within the general population. However, despite that, groups continued to deny those results and were instead largely guided by ideology and the financial self-interest spawned by the disease. HIV/AIDS was also a moral question, and the causes of the disease reflected a serious crisis of values. Prevention, first and foremost, should be directed towards individual development and education in proper human behaviour.
Member State statements - Meeting coverage (United Nations 2011b).	Ecuador had developed a national "Live Well" plan to combat the disease and was working on free universal health-care access focused on the rights and responsibilities of those living with HIV/AIDS. Kazakhstan: A national monitoring and evaluation system to address HIV/AIDS had been operational since 2005, and in 2008, a substitution therapy initiative for injecting-drug users was launched.
UNAIDS strategy	It is critical that we empower and facilitate young people as change

language (UNAIDS 2011c)	agents in activating their communities to redress harmful social norms governing sexuality, gender roles and other behaviour. Engage with networks of young people to disseminate prevention messages and. Work with networks of people who use drugs and service providers to ensure continuity in education, HIV treatment, harm reduction (38) and treatment of drug dependence in the context of HIV, the prevention of sexual transmission and care and support services for people who use drugs. Support education programmes that allow young people to understand and exercise their rights to information and to services.