Summary report

HIV Drug Resistance: Advocacy Strategy Meeting

Monday 19 – Tuesday 20 March 2018

Netherlands Ministry of Foreign Affairs
The Hague, The Netherlands

Contents

Critical topics:

Participants at this meeting identified the following topics as being critical to an international advocacy strategy for HIVDR:

- HIVDR should be presented as a 'HIV-quality of care' issue that requires community support, including thought leadership, engaging community organizations to monitor quality issues related to HIVDR (including digitally), developing quality measures to include and reflect HIVDR, targeted publication of articles, texts on the role of the community and working in partnership with community leaders to advocate for better quality HIV care.
- Evidence-informed but simplified messaging regarding HIVDR is required, including coordinated audience-specific messaging at key events such as IAS 2018 in Amsterdam (particularly in the Global Village) and through social media.
- Strong links between HIVDR and (new) key themes and/ or actors across the global HIV and broader health policy agenda should be explicitly made, particularly regarding the transition to dolutegravir (DTG), the roll-out of pre-exposure prophylaxis (PREP), the 'Test and Treat' (T&T) and Differentiated Care Models (DCM) and the combat of antimicrobial resistance (AMR).
- Advocacy efforts regarding HIVDR should be coordinated with WHO to support the implementation of the Global Action Plan on HIVDR; using WHO data to benchmark countries and regions to support advocacy; creating an advocacy task group; and, setting quantifiable targets for HIVDR.
- Digital mobile technologies can be utilized to strengthen efforts to tackle HIVDR and to create cost-efficiencies in service delivery, with further operational research to test and/ or scale up potential interventions.

One critical challenge which is yet to be resolved was ambiguity regarding which organisation (or group of organisations) should lead and coordinate global advocacy on HIVDR and the delivery of the activities identified throughout this paper. An institutional leader or leaders is required to progress the outcomes of this meeting; to convene key stakeholders; review progress; and, adapt advocacy efforts as necessary.

1. Meeting overview and objectives

This meeting convened high-level stakeholders including policymakers, researchers, advocates and implementers to discuss the development of a bold and persuasive advocacy strategy on HIV drug resistance (HIVDR). The meeting builds upon the first Joep Lange Institute (JLI) 'Noordwijk' meeting on HIV in September 2017 where HIVDR was discussed in detail, as well as the World Health Organisation (WHO) Global Action Plan (GAP) on HIVDR (2017-2012) that was launched at the IAS 2017 conference in Paris. Given the complexity and implications of HIVDR with respect to reaching global targets, this expert meeting focussed solely on developing an advocacy strategy for HIVDR was deemed imperative as part of the JLI 'Noordwijk' initiative.

The meeting was hosted at the premises of the Dutch Ministry of Foreign Affairs (MoFA), by JLI and the WHO, in partnership with PITCH (a strategic partnership between MoFA, Aidsfonds and the International HIV/AIDS Alliance). The goal of the meeting was to facilitate an expert discussion on HIVDR and define the building blocks of an international advocacy strategy going with and beyond the

GAP. This document highlights the most salient themes of the meeting with key recommendations to progress an HIVDR response.

Broadly, the meeting outcomes focus on:

- Positioning the underlying challenges of HIVDR as issue of 'quality of care';
- Developing clearer, evidence-informed HIVDR messaging;
- Linking HIVDR to other global health policy priorities, including anti-microbial resistance (AMR) and Universal Health Coverage (UHC);
- Strengthening coordination with WHO in pursuit of implementation of the GAP on HIVDR; and
- Leveraging digital mobile technology for HIVDR monitoring and reporting.

The meeting was attended by over 40 participants with technical expertise in HIVDR research, policy, programming, advocacy and funding. HIVDR is a cross-cutting issue requiring coordination of the scientific community, funders, advocates, ART programme managers as well as community and civil society. The meeting participants represented a truly diverse representation of civil society advocates, community representatives, health practitioners, medical researchers, and policy experts from across the globe. As a result, a great strength of this meeting was opening the discussion on HIVDR to such a broad spectrum of experts and facilitating the consideration of key cross-cutting issues regarding HIVDR.

The one-and-a-half-day programme included presentations, plenary discussions, break-out sessions guided by a draft theory of change, a final plenary, a feedback session, and statements of commitment. The following report synthesises these discussions as clear, actionable priorities for advocacy regarding HIVDR.

2. Introduction

HIVDR threatens to undermine the progress made by the global HIV/AIDS response. The 2017 WHO HIVDR report documents steadily increasing levels of HIVDR since 2001 in low- and middle-income countries among individuals starting first-line antiretroviral therapy (ART). Increasing levels of HIVDR have particularly been seen in Southern and Eastern Africa, with average pre-treatment drug resistance (PDR) levels below 5% in 2010[1] and more recent (2016) reports of 6 of 10 national surveys showing PDR >10% to first-line antiretroviral (ARV) drugs. In a situation with PDR>10%, 16% of AIDS deaths (890,000), 9% of new infections (450,000), and 8% ($6.5 billion) of ART program costs in SSA in 2016–2030 will be attributable to HIVDR[2].

HIVDR is caused by changes (mutations) in the genetic structure of HIV that affects the ability of a drug or combination of drugs to block the replication of the virus. HIVDR can emerge to all ARVs (although there are differences in propensity as ARVs have varying genetic barriers to the selection of resistance). HIVDR can be acquired drug resistance (resistance developed by a person who is on ARVs: ADR); transmitted drug resistance (infection by a drug resistant strain of HIV: TDR) and PDR (the more operational definition of pre-treatment drug resistance). Drug resistance mutations develop due to suboptimal plasma levels of ART drugs, allowing the virus to 'escape' and replicate again. Suboptimal plasma levels can be the result of a myriad of causes, that can be patient-related (lack of adherence due to stigma, mental health issues, food insecurity), drug-related (toxicities, pill burden, drug-drug interactions, prices), system-related (stock-outs, loss to follow-up, lack of access to viral load testing, lack of medical manpower) and virus-related (diversity, fitness, HIV subtypes).

HIVDR is currently underrepresented in the global HIV narrative and response, yet it poses a major and growing risk to existing investments as well as to reaching the WHO and UNAIDS "90-90-90" targets (90% of people living with HIV detected, 90% of them on ART and 90% of those on ART achieving virological suppression by 2020). Without tackling HIVDR head-on, yet more lives will be

[1] Hamers et al. Lancet Inf. Dis. 2011: 11:750-9.
[2] Phillips et al. Journal Infectious Diseases 2017;215:1362–5.

lost and what resources are available will face greater strain because of the need to treat an increasing number of HIV patients with more expensive second (3x) and third line (15x) ARVs.

At present, the WHO's GAP on HIVDR provides the most comprehensive strategic response to HIVDR. The GAP's strategic objectives are:

I. **Prevention and Response**
'Optimization of ART service delivery and elimination of programmatic gaps along the cascade of HIV testing, treatment and care services' - following WHO's normative guidelines.

II. **Monitoring and Surveillance**
Quality data on HIVDR is required for effective responses, and must be obtained through periodic surveys, increased routine viral load and HIVDR testing, and monitoring the quality of service delivery.

III. **Research and Innovation**
'Encouraging relevant and innovative research' to 'fill existing knowledge gaps'.

IV. **Laboratory capacity**
Increase laboratory capacity and quality to support increased viral load and HIVDR testing.

V. **Governance and enabling mechanisms:**
Ensure advocacy, country ownership, coordinated action and sustainable funding are in place for HIVDR prevention, including through cooperation between government and non-governmental stakeholders.

3. Key themes that emerged from the discussion

Using the GAP as a starting point, this meeting went further in discussing key priorities and actionable steps to ensure HIVDR is given more focus and resources. The following sections highlight the priority areas and concrete steps for advocacy that emerged from the meeting.

3.1. Present HIVDR as a quality of care issue, that requires increased community support

Incidence of HIVDR is primarily caused by critical quality-related issues that exist at multiple levels of HIV responses. These quality issues affect an individual's ability to consistently and optimally adhere to treatment regimens. Partial/suboptimal adherence to treatment can occur for various reasons, including patients who report late to collect treatment and experience treatment interruption, 'treatment holidays' or sharing of pills resulting in an individual taking a partial dose. Food insecurity, alcohol and depression also reduce a patient's adherence to treatment. The side-effects of treatment and, in some instances, costs associated with treatment monitoring can further disincentivize patient adherence.

Systemic challenges including drug supply chain problems (stock-outs or shortages), lack of laboratory monitoring, stigma and/or insufficient health care workers can also contribute to increased HIVDR. The importance of HIV care quality therefore surfaced as a salient issue within the meeting that deserves an acute advocacy focus. Seen through a quality of care lens, HIVDR moves from being a technical discussion to an issue directly relevant to the community response and health programme delivery and for this reason becomes more 'actionable'.

HIVDR is the result of suboptimal quality of HIV interventions. Especially where HIVDR is high or increasing and where evidence exists demonstrating poor performance of providers by HIVDR Early Warning Indicators (EWI), targeted advocacy by key population and patient networks could and should be supported to strengthen underlying quality of care issues (e.g. drug stock outs, insufficient or poorly trained healthcare workers). Moreover, it emerged that specific indicators should be developed that can help monitor the community support response to quality of care. These indicators can be mapped, providing important policy information and opening the possibilities of incentivizing community support through performance-based financing.

Within the meeting, the issue of quality of care became inseparable from a discussion of *health justice* - whereby all people have access to the means to avoid premature death and preventable morbidity (under the UHC premise). HIVDR can be considered a key indicator of the failure to deliver the comprehensive, accessible services that are core to health justice, the challenges of treatment adherence are direct manifestations of poverty and unequal health service access. High quality HIV interventions are required by all affected communities, but particularly by key populations (including men who have sex with men (MSM), commercial sex workers (CSWs), injection drug users (IDUs), migrants and adolescents) who are often 'under the radar screen of the health system' and therefore at enhanced risk of HIVDR because of suboptimal care, discrimination and/or poor coverage by services. Action on poverty and inequality is therefore essential to countering the incidence of HIVDR; and through the lens of poverty and inequality, we may also reliably predict HIVDR hotspots, for example by big-data analytics and geographical tagging.

Given decreasing international funding available, HIV responses are obliged to 'do more with less'. Moreover, medical-technical interventions alone will not be sufficient to minimize emergence and transmission of HIVDR. Community-based solutions will likely be the most efficient actions to improve quality of care, as community responses can be embedded at relatively low cost.

It was concluded that community involvement to prevent HIVDR emergence could be championed and facilitated, including in the areas of mental support, combatting stigma, peer outreach, partner notification, social networking, etc. The HIV sector traditionally has a highly motivated patient population unlike other health sectors, including strong key populations and patient networks capable of being vocal advocates for health justice. These highly motivated groups represent a cohort of key advocates to engage regarding all aspects of quality of care, including HIVDR. A new generation of HIV advocates representing mostly the communities in low and middle-income countries (LMICs) is needed.

Advocacy recommendations that emerged from the discussion:

- Produce a Viewpoint paper (in a peer-reviewed journal and/or elsewhere) detailing concrete actions that communities can take to advocate for and strengthen quality of care aimed to reduce and prevent HIVDR;
- Develop a set of quality of care indicators (both quantitative and qualitative) for community-supported HIV interventions that can monitor performance and lead to HIVDR reduction and ultimately prevention;
- Review global- and national-level facility-based measures and indicators of programme quality (EWI) to ensure they sufficiently include and reflect HIVDR;
- Use both above community and facility indicators to allow for benchmarking, hot spotting, mapping of HIVDR responses;
- Produce high-quality case studies documenting low-cost, high-impact community interventions that strengthen adherence, improve retention, minimize losses to follow-up, generate demand for VL testing and improve its use for patient management, and prevent drug stock out in resource-limited settings; and
- Create a cadre of community figureheads to raise awareness of HIVDR and advocate for better quality care.

3.2. Develop evidence-informed but simplified messaging regarding HIVDR

HIVDR continues to be viewed by many as highly technical and scientific. Significant scope remains for simplifying messaging regarding HIVDR to help experts outside of the research community understand its relevance and importance. For example, the relevance of HIVDR to the 2030 Agenda and the 2020 goal of 90-90-90 needs to be more clearly understood. Donors need to understand precisely how HIVDR fits within their existing investment portfolio, so it is not seen as an additional issue to focus on, but a natural part of existing priorities. The relevance of HIVDR must be made particularly clear to donors, national health policy makers, ministries, community groups, and civil society. For example, HIVDR is currently absent from Global Village sessions at the International AIDS Conference in Amsterdam, a key forum for reaching critical actors. Messaging regarding HIVDR

must also overcome the challenge it presents in providing a positive narrative around the HIV response. HIVDR points to failures in existing investments in health services, an 'inconvenient truth' at a time of challenging financial and political environments.

There is a large and growing body of data, guidance and tools relevant to HIVDR. While this body of evidence marks a significant resource, the understanding of and engagement with HIVDR is not considered strong outside of the research community, and therefore more needs to be done to communicate both the challenges of HIVDR and opportunities to counter it. A good understanding exists of the causal factors of HIVDR. Good practices and innovations designed to mitigate against these causal factors are documented (e.g. the use of mobile technology to prevent drug stock outs). There is a growing body of data regarding the current trends and prevalence of HIVDR (although there remain significant gaps, including of HIVDR trends in key populations) and emerging commodities (including DTG) will strengthen the response to HIVDR as part of well-resourced and high-quality HIV interventions.

Valuable lessons regarding communication channels and how to utilise them to convey a complex problem simply can be learnt from work regarding AMR. The Review of AMR delivered by Jim O'Neill[3] provided a valuable infographic and a crude but effective economic analysis that while not technically excellent was easy to understand and engage with and led to action. A current media campaign in the Netherlands was noted for conveying key messages regarding the responsible use of antibiotics. Learning can be taken from a creative and interactive event delivered at an EU Council meeting when the Dutch Government held the EU Presidency that strengthened understanding among Government Ministers of a highly technical issue.

Advocacy recommendations that emerged from the discussion:

- Develop a messaging framework for HIVDR, segmented by target audience and incorporating an underlying focus on health justice, to help advocates clearly communicate the relevance and importance of HIVDR to different stakeholders and decision makers. The messages will need to be tailored in their language to different audiences (e.g. key population and patient networks, health professionals or government donors) and to different opportunities (e.g. conferences or high-level meetings);
- Use the World Health Assembly, World Resistance Day, TB HLM, IAS Science 2019 and PCB Coordinating Boards as key messaging opportunities. Meeting participants especially focused on IAS 2018 in Amsterdam and the need to ensure messages regarding HIVDR feature in the Global Village; and
- Develop a coordinated social media campaign to communicate the relevance and importance of HIVDR.

3.3. Link HIVDR to (new) key themes and actors across the global health policy agenda

For government policy makers, HIVDR is just one more factor to consider alongside other key components of an effective HIV response in a challenging financial and political environment. Moreover, HIVDR can be seen by policy makers as a variation on the general theme of antimicrobial drug resistance (AMR) that affects far more people. To fit within a potentially saturated health policy agenda, it was concluded that advocacy for HIVDR would benefit from strategic links with new key themes and actors that drive the current HIV and health policy agendas.

The mobilization of resources for the global HIV and AIDS response over the course of the epidemic has been unprecedented in the history of public health. The challenge of funding a comprehensive response has been marked by unique and innovative mechanisms, unparalleled levels of bilateral aid and large-scale philanthropic donations. Most recently, these funding levels have regressed. Donor funding for the HIV response in low-and middle-income countries declined by 7% between 2015 and

[3] https://amr-review.org/sites/default/files/160525_Final%20paper_with%20cover.pdf

2016; the most important HIV fund, PEPFAR, will lose significant contributions[4]. Regression in funding levels follows several years of flat-line funding, leading to significant funding gaps and resource constraints that threaten to derail the overall HIV response. On top of this, the predicted number of HIV patients on more expensive second line ART will increase to a figure up to 5 million in the years to come[5].

Striking a balance between embedding HIVDR within existing priorities in the global health policy agenda to emphasize cost-efficiencies where they exist and highlighting the exceptional, urgent nature of HIVDR may generate support and interest in the issue from a broader audience of policy makers. In turn, striking this balance may support the case for greater investment in HIVDR. Embedding HIVDR, as an access and quality of care issue in the UHC agenda, for example, as well as creating greater clarity on how exactly HIVDR is (and is not) linked to AMR would provide valuable messaging around HIVDR.

Meeting participants recognised that HIVDR should particularly be a key consideration during the roll-out of DTG as a breakthrough first line regimen. DTG is not immune to drug resistance but has significantly higher genetic barriers than efavirenz. As access to DTG is scaled up, it is essential that sufficient focus is given to monitoring the quality of this intervention to protect a valuable first line regimen, avoid unnecessary expensive switching and curb potential development of DTG resistance. Meeting participants also recognised that the delivery of pre-exposure prophylaxis (PreP) and the current 'Test and Treat' (T&T) approaches as well as Differentiated Care Models (DCM) provide opportunities to deliver ART in ways that minimize treatment interruptions, maximise adherence and thus fight HIVDR if delivered effectively; or exacerbate HIVDR if not delivered effectively. The new interventions that are currently in the spotlight provide the opportunity to launch concomitant messages on HIVDR. For example, T&T will involve giving ART to healthy people whose motivation to adhere to treatment may differ from highly motivated people presenting symptoms, potentially increasing risk of HIVDR. A recent T&T study starting ART on the same day of HIV testing reports losing 1/3 patients from the care cascade, with unknown drug intake behaviour and HIVDR consequences[6]. HIVDR can emerge because of suboptimal adherence to PrEP regimens or when PrEP is administered in patients with undiagnosed recent infection.

Advocacy recommendations that emerged from the discussion:

- Focus advocacy regarding HIVDR on countries and donors for whom the transition to DTG, PreP, T&T, DCM and Treat All are strategic priorities, ensuring that measures and indicators of programme quality/ quality of care sufficiently include and reflect HIVDR; and
- Develop a coordinated strategy for HIVDR and AMR 'leads' to champion quality of care, a common key issue for both agendas;

3.4. Coordinate with WHO to support the implementation of the GAP

While this meeting looked beyond the implementation of the GAP to focus on advocacy regarding HIVDR more broadly, meeting participants recognised that the WHO's GAP on HIVDR provides the most comprehensive strategic response to HIVDR and subsequently represents a critical starting point for future advocacy. There is also a recognition among meeting participants that data collected by the WHO provide a valuable tool for advocacy around HIVDR. Meeting participants recognised that future advocacy around HIVDR can be informed by WHO's products and data, but that WHO systems and products could be further strengthened to include indicators and guidelines on community responses, be disseminated more broadly to support advocacy regarding HIVDR and to facilitate greater collaboration between the communities and actors represented at this meeting.

Advocacy recommendations that emerged from the discussion:

[4] http://foreignpolicy.com/2017/12/01/proposed-u-s-cuts-to-aids-funding-could-cause-millions-of-deaths-report-world-aids-day-hiv-global-health-pepfar-state-department-trump-one-campaign/
[5] https://www.ncbi.nlm.nih.gov/pubmed/26939736
[6] https://www.ncbi.nlm.nih.gov/pubmed/29509839

- Produce 'quality scorecards' based upon existing facility-level and national-level WHO data to allow for benchmarking of countries and regions ('traffic light') and designed specifically for use by and disseminated to advocates (using community indicators like: retention, access to viral load testing, individual virological failure, user-reported stock outs, supplemented with scoring facilities using EWIs with respect to on-time pill pick-ups, LTFU, appropriate switch, etc.).
- Establish a task group to oversee and support advocacy regarding HIVDR or assign several community and activism representatives to the HIVResNet Steering Committee;
- Help develop, stimulate application and analyse a (set of) quantifiable target(s) for advocacy regarding HIVDR (e.g. zero resistance by 2030); and
- Develop and map consolidated worldwide estimates of the number of people living with HIVDR to support advocacy.

3.5. Make use of new digital mobile technologies

Mobile phones are conquering developing countries, particularly in Africa. For example, more than half of the Kenyan economy is handled through a mobile phone system, M-PESA. In addition to feature phones, the use of smart phones is rapidly increasing, particularly amongst younger people, the most vulnerable population to HIV. During the meeting the potential of mobile phones in the HIV response was shared on many aspects. In particular mobile phones can give a voice to the thus far 'nameless' people in Africa: the millions who did not formally 'exist' (except when elections are concerned) now have a voice, can be reached and empowered. The mobile phone could become a tool to support the community response with respect to quality of HIV care in many ways. A good example is the development of M-TIBA in Kenya, a mobile digital healthcare exchange platform that facilitates health insurance, allows for (personal) health savings, remittances and can absorb international vertical funds to channel value to those who are in need, e.g. Global Fund to HIV patients. Digital HIV patient trackers are developed that indicate on a per-patient level the quality of care provided as compared to national guidelines. Thus, aberrations from guidelines (e.g. missed patient visits, viral load tests, incorrect ARV combinations) will be observable in (semi-) real time and corrective actions can be undertaken. Such HIV trackers can also be used as digital decision support systems, a feature that will become increasing important with the decentralisation of HIV care through the novel DCM. Mobile phones can be used to report stock-outs of ARVs by patients and community members, as exemplified in South Africa and Cameroon. For the vulnerable group of adolescents, the use of mobile phones is second-nature and provides unique opportunities in terms of digital peer-peer support, social networking and information sharing. The WHO indicators for quality of care in ART facilities (EWI for HIVDR) could be supplemented with a new set of mobile phone-based personal EWIs that are used by patients, communities to report on quality of care in a geo-targeted and real-time manner. Mobile phones can support so called 'connected diagnostics' systems, where point-of-care diagnostic data, e.g. HIV test results are used to channel funds to patient for novel and more efficient bottom-up payment systems.

Advocacy recommendations that emerged from the discussion:

- Establish or link to working groups that make an inventory of potential digital mobile phone-supported HIV interventions that are being used and could be used in the future;
- Support the development of mobile innovations in LMICs that support HIV prevention, testing, treatment and care; and
- Evaluate the impact of digital mobile interventions that improve quality and efficiency of care for HIV patients.

4. Conclusions and next steps

The themes that emerged and the associated insights gathered during this meeting define the building blocks of an advocacy strategy to ensure HIVDR receives greater focus and resources. Meeting participants identified the preferred tone of any advocacy regarding HIVDR; that key messages should be simple, accessible and incorporate a focus on health justice. The preferred focus of advocacy regarding HIVDR was identified by meeting participants, that it should directly tackle

quality of care. Affected communities should be directly involved in both advocacy and data collection, for example, and links should be explicitly drawn between HIVDR and (new) key themes or actors (including AMR, the roll out of DTG, PreP, and T&T) to ensure the relevance of HIVDR is clear to all key decision-makers and the issue resonates in a saturated global health policy agenda.

Specific and concrete activities have been highlighted by meeting participants that will support the delivery of these key components of future advocacy on HIVDR. A critical challenge that emerged during the meeting and which is yet to be resolved, was ambiguity regarding which organisation or group of organizations should lead and coordinate global advocacy on HIVDR and the delivery of the activities identified throughout this paper. Meeting participants represent a valuable group of engaged and like-minded experts and organisations that outlined their commitment to raise awareness of HIVDR and implement the recommendations that emerged from the discussions. An institutional leader or leaders is perhaps required, however, to convene key stakeholders, review progress and adapt advocacy efforts as necessary. To this end, JLI and WHO will schedule a follow up meeting at the IAS2018 in Amsterdam to report back to attendees of this meeting and agree ways of communicating, coordinating and supporting further coordinated action to address HIVDR.

Annex 1: List of participants

1. Ava Avalos
2. Sulaimon Akanmu
3. David Barr
4. Silvia Bertagnolio
5. Thomas Cai
6. Matteo Cassolato
7. Martin Choo
8. Nick Corby
9. Diane Descamps
10. Louise van Deth
11. Ricardo Diaz
12. Meg Doherty
13. Michiel Heidenrijk
14. Khalil Elouardighi
15. Marja Esveld
16. Raman Gangakhedkar
17. Pedro Garcia
18. Lambert Grijns
19. Raph Hamers
20. Gottfried Hirnschall
21. Charles Holmes
22. Seth Inzaule
23. Ravi Gupta
24. Fungai Kavenga
25. Irene Keizer
26. Els Klinkert
27. Maria le Grand
28. Joost Lina
29. Lynette Mabote
30. Anita Mesic
31. Monique Middelhof
32. Peter Mugyenyi
33. Irene Mukui
34. Moses ‘Supercharger’ Nsubuga
35. Anton Ofield-Kerr
36. Deborah Persaud
37. Annette Reinisch
38. Tobias Rinke de Wit
39. Peter van Rooijen
40. Asia Russell
41. Birgit Schramm
42. Constance Schultsz
43. Kenly Sikwese
44. Annette Sohn
45. Marcel Vaessen

Annex 2: Meeting programme

Day 1: Monday 19th March

11.30-12.00	Registration at the Ministry of Foreign Affairs* *Passport or form of ID needed
12.00-12.30	Participants arrive and lunch available
12.30-13.30	**Welcome and why are we here?** **Lambert Grijns** Dutch Ambassador for Sexual and Reproductive Health and Rights & HIV/AIDS, Ministry of Foreign Affairs of the Netherlands **Michiel Heidenrijk** Executive Director, Joep Lange Institute **Louise van Deth** Executive Director, AIDSFONDS **Gottfried Hirnschall** Director HIV and Hepatitis Division, WHO **Facilitator's presentation of the agenda and introductions** **Anton Ofield-Kerr** Director, Equal International
13.30-15.30	**1. HIVDR: an inconvenient truth** Evidence shows that HIVDR is a threat to persons living with HIV, to achieving the 90-90-90 targets and to current investments in HIV. This session will provide current data and evidence regarding HIVDR, it's causes and the projected human and financial impact of HIVDR. It will also compare the lack of political focus on HIVDR in comparison to ongoing efforts to address multi drug resistant tuberculosis and antimicrobial resistance. This session will ask, based on the lived experience of HIVDR what are the most urgent things that need changing? **Meg Doherty** Coordinator Treatment and Care, Department of HIV and Global Hepatitis Programme, World Health Organisation. **Tobias Rinke de Wit** Research Director, Joep Lange Institute **Peter Mugyenyi** Former CEO, Joint Clinical Research Plenary discussion.
15.30-15.45	Tea/ coffee
15.45-16.45	**2. Key elements of a global response to HIVDR** Solutions exist to respond to HIVDR. This session will identify potential solutions, looking specifically at: the Global Action Plan (GAP) on HIVDR; ART and what progress has been made to date regarding the switch to dolutegravir based regimens and whether this is the 'silver bullet'; as well as what progress has been made regarding viral load testing. **Chair: Gottfried Hirnschall** Director HIV and Hepatitis Division, WHO **Silvia Bertagnolio** HIVDR Technical Lead, WHO

	Raph Hamers Senior Scientist, Eijkman-Oxford Clinical Research Unit (EOCRU) **Anita Mesic** HIV, TB, Hepatitis Advisor, MSF Plenary discussion.
16.45-17.30	**3. Turning inaction into action** Given that HIVDR poses a threat to persons living with HIV and to progress made towards eliminating HIV this session will identify the barriers to action on HIVDR and what is needed to strengthen the response to HIVDR including at policy level. What opportunities exist? What aspects of HIVDR and the response to it initially present as salient advocacy priorities? **Els Klinkert** Senior Adviser HIV and SRHR, Ministry of Foreign Affairs of the Netherlands **Maria le Grand** Policy Officer, Ministry of Health, Welfare and Sport **Martin Choo** General Manager, Kuala Lumpur AIDS Support Services Society **Asia Russell** Executive Director, Health GAP, Uganda Plenary discussion.
17.30-17.45	**Reflections on Day 1** **Michiel Heidenrijk (or MOFA/MOH)** Executive Director, JLI
19.00-21.00	**Network reception followed by dinner**

Day 2: Tuesday 20th March

08.30-09.00	Registration at Ministry of Foreign Affairs* *Passport or form of ID needed
09.00-09.45	**Reflection on Day 1** **Gottfried Hirnschall** Director HIV and Hepatitis Division, WHO Plenary discussion. **Ambition for Day 2** **Monique Middelhoff** Senior Adviser Health and HIV, Ministry of Foreign Affairs of the Netherlands **David Barr** Consultant
09.45-10.45	**4. Identifying the key components of a robust advocacy strategy to tackle HIVDR** This session will identify the key components of a bold and persuasive advocacy strategy designed to enhance commitment among key UN agencies, donors, national governments, advocates and implementers to address HIVDR as an integral component of global, regional and national HIV responses. The session will be introduced in plenary followed by discussion in four smaller groups to discuss how to bring about real change. **Overview of Theory of Change based advocacy strategy** **Anton Ofield-Kerr** Director, Equal International **Working Group 1: Who are the key stakeholders ('people') we need to engage?** **Facilitator: Constance Schultsz** Deputy Head of the Department of Global Health, AIGHD **Working Group 2: How do we engage and strengthen services and service providers?** **Facilitator: David Barr** Consultant **Working Group 3: How do we make the politics work?** **Facilitator: Martin Choo** General Manager, Kuala Lumpur AIDS Support Services Society **Working Group 4: How do we secure sufficient resources for HIVDR? (the 'payers')** **Facilitator: Annette Sohn** Vice President and Director, TreatAsia
10.45-11.00	Tea/ coffee
11.00-12.30	**5. Building a robust advocacy strategy to tackle HIVDR** A rapporteur from each group will summarise key points from their breakout groups followed by round-table discussion to start to agree: • What is our goal(s)? • Who needs to be engaged and convinced? • What should be our approach to mobilising action? • What messaging is needed to convince key stakeholders? • What are the key influencing opportunities? **Facilitator: Anton Ofield-Kerr** Director, Equal International
12.30-13.30	Lunch
13.30-14.30	**6. Reflections and clarifying policy pressure points, actions and tactics** **Dr. Peter van Rooijen** Executive Director, ICSS

	Plenary discussion to validate and prioritise agreed actions.
14.30-15.00	Tea/ coffee
15.00-16.00	**7. Implementing our advocacy strategy / action plan** Our robust advocacy strategy to tackle HIVDR requires detailed, coordinated and immediate work that takes advantage of key moments and processes over the next 6 - 24 months This session will focus on agreeing key actions needed, personal commitments and a division of labour that utilises participants reach and influence. **Summary of Agreed Actions and next steps** **Anton Ofield-Kerr** Director, Equal International **Final remarks:** **Tobias Rinke de Wit** Research Director, Joep Lange Institute **Louise van Deth** Executive Director, AIDSFONDS **Gottfried Hirnschall** Director HIV and Hepatitis Division, WHO
1600	Participants depart.