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# PROGRAMME COORDINATING BOARD

**Sixteenth meeting**
**Montego Bay, Jamaica, 14-15 December 2004**

***Provisional agenda item 3:***

## Intensifying HIV Prevention—Foundations for a Strategy Framework

**Executive Summary**
At the 15th Meeting of the Programme Coordinating Board (PCB) in June 2004, the Board requested the UNAIDS Secretariat to develop a global strategy to intensify HIV prevention. It also decided that HIV prevention would be one of two substantive issues to be discussed at its thematic meeting in December 2004.

Enormous progress has been made in recent years in focusing global attention on the need to expand access to HIV treatment, care and support. However, it is important that these efforts are part of comprehensive AIDS strategies that balance prevention and treatment.

The UNAIDS Secretariat and Cosponsors are therefore developing a strategy to place HIV prevention more centrally on the global AIDS agenda, and which is underpinned by the UNGASS Declaration of Commitment and the Global Strategy Framework on HIV/AIDS, agreed by the Programme Coordinating Board in 2001. Some key actions central to the strategy which UNAIDS will develop are harnessing existing and new resources and enhancing new ways of using funds; building synergies between HIV prevention and treatment; developing a results-based focus in HIV prevention; enhancing human, institutional and community capacity to deliver and manage comprehensive HIV prevention and treatment programmes; ensuring coordination among all players in line with the "Three Ones" principles; developing a comprehensive response to HIV prevention towards reducing risk, vulnerability and impact; strengthening evidence-informed HIV prevention programming and the empirical base for action; building a vocal constituency of divergent players for HIV prevention; and promoting the engagement and involvement of people living with HIV.

This paper proposes a three stage process of consultation to finalize the development of the global HIV prevention strategy; discussion and agreement at this Programme Coordinating Board meeting of the key principles that should underpin the development of this strategy framework and broad actions proposed; incorporation of Board inputs and further consultation with key partners, including UNAIDS Cosponsors; and consideration of a finalized draft strategy by the Programme Coordinating Board at its next meeting in June 2005.

**Action Required from this meeting**
It is requested that the Programme Coordinating Board:
i. Agree to the principles underlying the development of the global HIV prevention strategy framework;
ii. Agree to the implementation of a three stage process to finalize the global HIV prevention strategy;
iii. Provide inputs to guide the development of the global HIV prevention strategy.

## 1. Background

The world stands poised on the verge of a new era in the response to AIDS. The call for increased access to treatment has been rewarded by the increased availability of antiretroviral drugs, the reduction of prices of these drugs in many countries, and additional funds towards the AIDS response.

In addition, there are encouraging signs that progress is being made against the epidemic. Despite continuing growth in many parts of the world, HIV prevalence has dropped at national level in countries such as Cambodia, Thailand and Uganda, and at subnational level in parts of the Bahamas, Barbados, the Dominican Republic, Ethiopia, Kenya, and in Tamil Nadu in India. Brazil has successfully scaled up prevention alongside access to antiretroviral treatment.

By building on lessons learned so far, and taking advantages of the prevention opportunities provided by enhanced access to antiretroviral treatment, a comprehensive response to AIDS as recommended in the United Nations General Assembly Special Session (UNGASS) *Declaration of Commitment on HIV/AIDS* can be implemented for the first time on the scale needed.

The UNAIDS Secretariat and Cosponsors are therefore developing a strategy to place HIV prevention more centrally on the global AIDS agenda.

## 2. The way forward: steps in the development of a strategy for intensifying prevention

Considering the complexity of the response to HIV and the diversity of stakeholders involved, the UNAIDS strategy for *Intensifying HIV Prevention* is being developed in three steps. The first part, presented here, outlines key issues and broad actions to be taken by UNAIDS, its partners and its stakeholders. It describes a process of how to collectively scale up HIV prevention, build capacity at country level and show results. The Secretariat initiated consultation within the UNAIDS family, with several country-level partners, and with civil society organizations[1] to develop this element of the strategy.

This initial element of the strategy will be expanded in the second stage following the Programme Coordinating Board's guidance to be provided in December 2004. Subsequently, UNAIDS proposes that a series of consultations be undertaken in the first quarter of 2005 to review the essential actions necessary to build capacity to scale up prevention. Stakeholder workshops organized for this purpose will bring together UNAIDS Secretariat and Cosponsors; representatives of the UNAIDS Reference Group on Prevention; national governments; civil society organizations, including nongovernmental organizations working on HIV; mainstream nongovernmental organizations; trades unions; private sector representatives; young people; representatives of organizations of affected populations, including networks of people living with HIV; and donors.

Consultations among relevant partners will take place around the practical actions to be implemented as part of an effective and operational HIV-prevention strategy at country level. Consultations will focus particularly on the following strategic areas from an operational perspective: reducing risk; addressing vulnerability; reducing impact; and achieving a

[1] UNAIDS would like to acknowledge with gratitude the contributions of the International HIV/AIDS Alliance, which carried out an electronic consultation with civil society to provide inputs to the strategy framework.

differentiated response. They will lead to the development of a second document detailing consensus approaches on the critical elements of the strategy and the actions necessary to intensify and scale up HIV prevention. This will be presented to the Programme Coordinating Board in June 2005.

## 3. Principles underlying the Strategy

This strategy framework is based on the *Global Strategy Framework on HIV/AIDS* endorsed by the Programme Coordinating Board in Rio de Janeiro in 2001, and identifies the critical elements of prevention which need to be resourced and scaled-up[2].

### *The Global Strategy Framework on HIV/AIDS*

The proposed HIV-prevention strategy framework will be based on the *Global Strategy Framework on HIV/AIDS* which recognizes the exceptionalism of the AIDS epidemic, and highlights the importance of efforts to tackle gender disparities, promote human rights, and ensure that HIV prevention methods, treatment and the results of scientific breakthroughs are equitably and affordably available to all. The *Framework* signals the need for people living with HIV to have a central role in HIV prevention, impact mitigation, stigma reduction, treatment and care.

In particular, the *Global Strategy Framework on HIV/AIDS* identifies three interrelated factors as affecting the success of prevention strategies:


***Reducing individual risk to HIV***, including the delay of first sexual activity, safer sexual practices such as consistent condom use, reducing the number of sexual partners, and the prevention and treatment of sexually transmitted infections. In addition, the *Global Strategy Framework on HIV/AIDS* also identifies the prevention of HIV transmission through blood and blood products, the reduction of harm associated with drug use, particularly among young people, and the avoidance of unsafe injections, as well as the prevention of mother-to-child

[2] UNAIDS (2001), *Global Strategy Framework on HIV/AIDS*, Geneva, UNAIDS.

transmission. It notes that individual risk-reduction programming is most effective when targeted to meet the specific needs of clearly defined populations. Central to success in risk reduction is an appropriate scale and level of response and a willingness to promote the full range of risk-reduction strategies that have been shown to work.

***Reducing vulnerability,*** defined as a measure of an individual's or community's inability to control their risk of infection. Vulnerability reduction needs to be directed at individual, community and societal levels, and includes actions to tackle the underlying political, legal economic and social factors that drive the epidemic. Political commitment and bold leadership are required to address these factors which include traditional and cultural norms and practices, and lack of access to education.

Of particular importance are actions to address the special vulnerability of women and girls. It is also vital to decrease young peoples' vulnerability to HIV by ensuring that they have access to HIV-prevention education and the full range of HIV-prevention information, services and commodities. Actions to protect young people from poverty, exploitation, trafficking and sexual abuse are also important. Efforts must be made to reduce the social exclusion of people living with HIV by protecting their legal, political and economic rights, and by ensuring their integral participation in policies and programmes related to prevention, care and treatment.

***Reducing society and community level impact*** of AIDS, which decreases both individual risk and vulnerability to HIV. Impact-mitigation programmes are needed to bolster communities, for example through the promotion of income generating activities and food security for affected, vulnerable populations. Families may need help in maintaining their homes when disability and death occurs. Providing care and treatment to people living with HIV is a critical element in impact reduction to allow them to remain productive and secure livelihoods for themselves and their families. Prolonging the lives of parents and other adults is key in reducing the vulnerability of young people and orphans.

### *Achieving a differentiated response*

The HIV epidemic consists of a series of multiple and overlapping micro-epidemics, each with its own nature (the populations and groups most affected), dynamics (patterns of change over time) and characteristics (severity of impact). Because of this, HIV prevention must be fine-tuned to fit local epidemics and needs. In low-prevalence settings where the epidemic is nascent, attention needs to be given to HIV prevention among those at highest risk in those settings, identified after careful epidemiological and social mapping. In high-prevalence settings, a focus on such populations is critical alongside broader strategies to reach all segments of society at sufficient scale in order to turn the epidemic around. In all settings, addressing young people and women is imperative.

## 4. Goals and Objectives of the Strategy

### *The UNGASS Declaration of Commitment*

The overall goals for the proposed HIV prevention strategy framework are those of the *Declaration of Commitment* endorsed by all member states of the United Nations at the General Assembly Special Session on HIV/AIDS in 2001 (Annex 1). The *Declaration of Commitment* highlights the important role of HIV prevention in the response to AIDS, together

with its links to treatment and care as part of a comprehensive response to the epidemic. It also sets targets for the reduction of infection, including:

- by 2005, reducing HIV prevalence among young men and women aged 15 to 24 in the most-affected countries by 25% and globally, by 25% by 2010;
- by 2005, reducing the proportion of infants infected with HIV by 20% and by 2010 by 50% as well as ensuring that 80% of pregnant women accessing antenatal care have information, counselling and other HIV prevention services available to them;
- by 2005, strengthening the response to HIV in the world of work; and
- by 2005, developing and beginning to implement national, regional and international strategies that facilitate access to HIV prevention programmes for migrant and mobile populations.

Significant progress has still to be made to achieve the UNGASS goals and efforts to address the needs of vulnerable populations remain uneven. A mid-term analysis suggests that in several areas, progress is commendable in some countries, but globally, progress is far from satisfactory on several targets (Annex 2).

Specific objectives of the strategy framework therefore include:

- scaling up HIV prevention to meet the prevention gap and increase access;
- re-defining HIV prevention in the context of availability of treatment and harnessing the synergy between prevention and treatment; and
- energizing all sectors and constituencies, especially underutilized ones, with a sense of passion and urgency towards building a comprehensive response.

These objectives will be achieved through:

- enhanced resources for HIV prevention through multiple channels and avenues and strategic use of existing funds and opportunities;
- building on the synergies between prevention and treatment and scale up of successful HIV-prevention programmes;
- a results-oriented focus in HIV prevention and tracking of results;
- building human, institutional and community resource capacity to deliver and manage comprehensive HIV prevention and treatment programmes;
- significantly enhanced coordination among all players in HIV prevention including governments, civil society, and donors in line with the principles outlined in the "Three Ones";
- strong engagement and involvement of people living with HIV in prevention scale up;
- the promotion of comprehensive approaches in HIV prevention programmes and policies towards reducing risk, vulnerability and impact;
- evidence-informed HIV prevention programmes and policies and a strengthened empirical base for action; and
- a vocal constituency for HIV prevention which comes from different walks of life and sectors and therefore, reaches divergent populations and viewpoints.

Much of the above may seem obvious and may not appear to be new. Yet, we have not been able to take our past learning to scale nor, furthermore, to show results. What is new about this strategy framework, therefore, is its focus on how the UN system, donors, national governments and their civil society partners work together to *operationalize* these learnings and show results.

## 5. Taking HIV prevention to scale: barriers and opportunities

The growing availability of antiretroviral treatment offers dramatic new opportunities for prevention, in particular, by providing incentive to learn one's HIV infection status[3]. This availability at the same time creates challenges which require a redefinition of HIV prevention and its place in the overall response to AIDS. In addition, the attention and resources now available in the fight against AIDS and the growing number of committed players can be effectively harnessed to bring HIV prevention to scale. This strategy framework considers both the opportunities and challenges of this rapidly changing environment.

### *Barriers to taking prevention to scale*

Barriers to the implementation of effective HIV prevention programmes are of two broad types—environmental/contextual and operational.

Environmental and contextual barriers have their origins in political, social, cultural and ideological environments. Important factors include: lack of political commitment to addressing AIDS; cultural barriers in responding to the needs of vulnerable populations; a reluctance to recognize the value and capacity of civil society; and an unwillingness and/or inability to provide access to the full range of options that are known to be successful in HIV prevention.

Often, however, operational barriers such as those related to resources and resource utilization, capacity, and the limitations of prevention approaches prevent a strong HIV prevention response on the ground (See Box 1).

**Box 1**

**Some operational barriers to prevention scale up**

- Failure to bring promising programmes and approaches to scale and overemphasis on pilot and demonstration projects with unproven sustainability.
- Inadequate levels of resources and inappropriate utilization of available resources.
- Low capacity to track and show results of programmes.
- Limited human and institutional capacity to manage and deliver HIV programmes.
- Financial and administrative barriers at country level, which prevent money from being used effectively and quickly.
- Failure to implement a diversified response that is attuned to rapidly changing local circumstances and needs and local epidemics.
- Rapidly changing priorities and conflicting requirements of donors and other 'external' agencies.

Both these sets of barriers need to be addressed through operational measures designed with country-level partners in order to scale up HIV prevention. In addressing these barriers, the following principles need to be kept in mind.

[3] Global HIV Prevention Working Group (2004) *HIV Prevention in the Era of Expanded Treatment Access*, June.

***Maximizing synergy between treatment, prevention and care***

Despite the continuing spread of HIV, the increasing availability of treatment offers hope to millions of infected people worldwide. Antiretroviral treatment is a vital element of the response to AIDS in its own right, but also offers a context and opportunities to enhance prevention. The increased availability of treatment through initiatives such as "3 by 5" offers a major incentive for individuals to learn their HIV status.

Scaling up of HIV testing and counselling can serve as a critical entry point for both HIV prevention and treatment and act as a bridge between HIV prevention, treatment and care. Increasing the numbers of people who are aware of their HIV infection can also help reduce the silence and denial around AIDS, and create a more enabling environment for accessing prevention and treatment services.

While enhanced treatment availability offers considerable hope for the future, unless the incidence of HIV is sharply reduced, HIV treatment will not be able to keep pace with all those who need therapy. The synergy between prevention, treatment and care is therefore greater now than ever before. In the context of expanded treatment access, it is vital that those who test HIV-negative are supported in remaining negative. For those who test HIV-positive, care and support should stress ways of staying healthy and avoiding transmitting infection to others, both before and after commencing antiretroviral treatment.

An intensification and re-focusing of prevention, therefore, requires focusing on prevention for people living with HIV, integrating prevention into settings where treatment is offered, increased access to testing and counselling and reducing stigma and discrimination.

***Meeting the needs of the most vulnerable***

In every country, there are serious gaps in meeting the needs of vulnerable populations[4]. Where programmes have been implemented, they have often lacked the intensity and duration to have population level impact[5]. To be effective, prevention efforts must address the behaviours and situations that increase risk for HIV and enhance vulnerability, and the situations in which risk and vulnerability converge. This involves making services and information available and accessible to vulnerable populations.

Stigma, discrimination and violence keep people away from HIV-prevention services and the means to avoid HIV infection. Yet the majority of countries worldwide have no legal protection in place to prohibit discrimination against vulnerable populations, and more than one half of countries in sub-Saharan Africa do not have laws to prevent discrimination on the basis of a person's HIV-positive status[6]. Much work needs to be done to create legal and policy environments which enable HIV prevention.

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[4] USAID, UNAIDS, WHO, UNICEF and the Policy Project (2004) *Coverage of Selected Services for HIV Prevention, Care and Support in Low- and Middle-Income Countries in 2003*. Washington, DC, Futures Group.
[5] UNAIDS (2003) *Progress Report on the Global Response to the HIV/AIDS Epidemic, 2003*. Geneva, UNAIDS.
[6] UNAIDS (2003) *Progress Report on the Global Response to the HIV/AIDS Epidemic, 2003. Geneva*, UNAIDS.

***Dealing with structural factors***

HIV prevention efforts have largely ignored the structural factors that increase vulnerability. In order for HIV prevention to work, it is essential to create an enabling environment. For example, greater equity in educational, vocational and employment opportunities are known to reduce the possibility that girls will need to resort to unsafe sex with older men in order to survive. Providing social support services to refugees or internally displaced persons and ensuring food security reduces the possibilities of non-consensual and transactional sex in specific settings.

HIV-specific prevention programmes are not always able to directly include efforts to bring about change in many of the structural factors. Neither can we wait until all the structural factors are addressed before we can hope for an end to AIDS. HIV prevention should therefore work in synergy with ongoing initiatives and development efforts—governmental and nongovernmental—programmatically directed at reducing the influence of many of these structural factors. Vulnerability to AIDS created by these structural factors needs to be factored into programmes and policies to create an enabling climate for HIV prevention. Resources and attention need to be paid to strengthening such policies and programmes along with resources directed specifically at HIV risk reduction programmes.

***Tackling gender disparities***

Even though well-documented social disparities make women and girls especially vulnerable to HIV infection, nearly one third of countries lack policies to ensure women's equal access to HIV prevention and AIDS care. In many countries, young women's knowledge of basic facts about HIV is poor—often the result of policies that deny women and girls access to HIV education. Gender violence, or the threat of it, makes it hard for women to protect themselves and their partners against infection. Pervasive gender disparities—including in access to prevention, care and treatment, in property and inheritance rights, and in education and employment opportunities along with absence of availability of gender sensitive prevention technologies—highlight the need to combine short- and longer-term efforts in HIV prevention. Interim, crisis-driven solutions may bring temporary relief, but will prove inadequate in the long run if the conditions that enable HIV to spread are left intact.

**Box 2**

**Key action areas identified by the Global Coalition on Women and AIDS:**

- preventing HIV infection among young women and girls, focusing on improved reproductive health care;
- reducing violence against women;
- protecting the property and inheritance rights of women and girls;
- ensuring equal access by women and girls to care and treatment;
- supporting improved community-based care with a special focus on women and girls;
- promoting access to new prevention options including the female condom and microbicides; and
- supporting ongoing efforts towards universal education for girls.

***Working with young people***

Regardless of their sex, young people everywhere report that the education they receive about HIV is too little too late. Adults are often hesitant to provide young people with the facts about AIDS and with HIV prevention resources. Young people need access to a range of information, life skills, and prevention methods like condoms to be able to opt for healthy choices in risky situations. Comprehensive prevention means encouraging young people and supporting them to be aware of their options for a safe life, and support them in making the right choices for their situation and context.

**Box 3**

**Some evidence-informed approaches to working with young people**

- Youth participation in planning and implementation of programmes.
- Comprehensive life skills and sex and relationships education in and out of school.
- Peer-led programming to inform and encourage young people to protect their health.
- Youth friendly health services offering HIV testing and counselling, and services for the diagnosis and treatment of sexually transmitted infections.
- Harm reduction to prevent HIV transmission through injecting drug use along with demand-reduction programmes, and health services directed to other vulnerable groups, such as young sex workers and mobile populations.
- Community-based programmes for young men and education of young women to tackle sexual coercion and other forms of violence.
- Sustained media campaigns using communications channels that young people find credible and acceptable to promote gender equitable norms and HIV prevention education.

Adapted from WHO (2004) *Steady, Ready, Go!* Report of a Global Consultation organized by WHO, Talloires, and UNICEF (2002) *Young People and HIV/AIDS: Opportunity in Crisis.*

***Addressing the challenges of development, urbanization and migration***

Poverty eradication is a priority in most developing countries. In view of the links between poverty and AIDS, it is critical to ensure that programmes and policies for poverty eradication are informed by the impact of AIDS. Efforts to meet the Millennium Development Goals need to be particularly cognizant of these connections and of the links between economic and financial policies and AIDS. There needs also to be greater understanding of the reality that economic and financial policies designed to stimulate economic growth can sometimes increase vulnerability. Economic migration, for example, can break up families, resulting in risk behaviour. Greater efforts to develop rural economies through employment possibilities, increased incentives for rural development, and programmes which can prevent unplanned migration as well as policies which enable families to remain together, help to create conditions which address this vulnerability.

***Nurturing new players***

In order to make the response to AIDS truly multisectoral, attention has been focused on bringing in new players. Efforts in this area have, however, been slow to show results. For example, while the engagement of the business community and workers' unions in AIDS is

becoming stronger, relatively few medium- and small-scale enterprises see AIDS as a corporate problem, and only a very few smaller businesses have adopted comprehensive workplace policies in the face of the epidemic. Efforts should be made to involve all the players in this sector. The integration of HIV prevention and AIDS care into workplace policies in government and nongovernmental sectors is also uneven, despite the fact that good practice guidelines exist[7]. Virtually no prevention work is taking place in the informal economic sector, where the majority of workers can be found in the poorest countries of the world.

It is encouraging however, that faith-based organizations, community and sports' associations, cultural organizations, youth organizations and women's organizations are increasingly coming forward to respond to AIDS. The involvement of such organizations needs to be fostered to ensure that services and information are adapted to the realities of the populations which they serve and located in proximity to their constituencies, rather than keeping them limited to a few sectors, which are not always ideal as the first point of entry for such information and services.

***Financing new technologies for prevention***

New technologies for prevention, such as microbicides and vaccines, are an essential element of any comprehensive response. Investment in the development of such technologies however remains limited as compared to the need. Microbicides, in particular, have the potential to put women more in control of prevention decisions. Recent modelling has suggested that a 60% effective microbicide used by 20% of people currently in contact with HIV prevention services in the 73 low-income countries could avert over 2.5m infections in the three years after its introduction[8]. Continued investment in vaccine development is equally essential. In 2000, International AIDS Vaccine Initiative (IAVI) called for a threefold increase in global spending on an AIDS vaccine, from US$ 350 million annually to US$ 1.1 billion. Today, IAVI estimates that spending is US$ 650 million. This represents less than 1% of total spending on all health product development[9]. While vaccines and microbicides might not provide the answer for the immediate future due to the time it takes for their development, inadequate investment in them today has major implications for their availability at any point in the future.

***Greater involvement of people living with HIV and of affected communities***

The greater involvement of people living with HIV has been seen as integral to the response to AIDS for some time but with the advent of treatment, the expertise and involvement of people living with HIV become increasingly central to prevention success. Ensuring access to good quality HIV-prevention services for people living with HIV will be increasingly important as more people are tested and learn their HIV infection status. Experience indicates that people on antiretroviral treatment adopt safer behaviour if they understand the issues and receive ongoing counselling and other services. Maximizing the health of HIV-positive individuals, and enabling people living with HIV to play a fuller role in prevention, should help maintain safer behaviour and maximize the quality of life.

[7] ILO (2001) *Code of Practice on HIV/AIDS and the World of Work*. Geneva, ILO.
[8] Public Health Working Group, Microbicides Initiative (2001) *The Public Health Benefits of Microbicides in Lower Income Countries: Model Projections. New York,* Rockefeller Foundation.
[9] http://www.iavi.org/science/state.asp

## 6. Planning for success, working for results

The multiple ramifications and impact of AIDS have often caught the world unaware, especially in the early years of the epidemic. With more knowledge and experience, broader understanding of the epidemic's diverse and multisectoral implications, and growing realization of the exceptionalism of AIDS, the global community can no longer afford to be only reactive in order to meet the ever-growing challenges. A more proactive approach is needed to ensure actions on several fronts. Increased funding from all sources including national level is imperative. Efforts are required to ensure exceptional actions in financing, development, debt relief, trade rules, public service delivery and fiscal ceilings as well in identifying new and unexplored avenues for funding. Existing funding streams and mechanisms need to be reviewed to maximise their commitment to HIV prevention. Though much of this agenda is not related to HIV prevention alone, it is integral to its success.

With respect to HIV prevention, future strategy development must focus on developing the specific roles and responsibilities of different constituencies, including the UN system, in the scale up of prevention to harness the *synergy between treatment and prevention*, and to bring more energy into efforts to build an *evidence-informed, comprehensive response*. This effort will require ownership and commitment at all levels. Through all of these efforts, opportunities for *greater involvement of people living with HIV* and affected communities need to be enhanced. Key to success will be a critical examination of ongoing efforts as well as an identification of gaps and opportunities for combining forces. The development of HIV-prevention programmes as part of comprehensive national AIDS strategies need to be incorporated in the broader harmonization of AIDS funding approaches, as set out under the "Three Ones" principles. Opportunities for joint work, playing to institutional comparative advantage should be identified, alongside needed changes in institutional behaviour.

There is also a need for commitment to *results* at the national level as well as in sectoral and collective efforts. The focus needs to be on 'making the money work', unlocking the administrative and institutional obstacles and *capacity strengthening* to manage and deliver programmes and monitor and evaluate them.

Sound policies and effective action in the areas of prevention, require reliable information. Strategic information is critical to good decision-making at every level of a country's response to AIDS and will be particularly important as prevention activities are expanded in scope and scale. The UNAIDS 2003 *Progress Report on the Global Response to the HIV/AIDS Epidemic*, however, revealed that weak monitoring and evaluation systems were among the top four challenges to reaching the targets set out in the *Declaration of Commitment on HIV/AIDS*, with three quarters of responding states lacking the capacity to monitor the epidemic and to evaluate programmes.

National monitoring and evaluation systems need to be strengthened to make strategic information available, for which substantial technical and financial support is needed. Monitoring and evaluation need to become a core component of AIDS programmes at community, district, state/provincial and national levels for this to happen.

Well-functioning unified monitoring and evaluation systems should also support the completion of periodic evaluation research and assessments to inform the design of new programmes and document lessons learned, both positive and negative, in addition to analysing the costs, cost-effectiveness and sustainability of existing and planned actions. UNAIDS

Secretariat will therefore work with its Cosponsors and encourage its partners to develop a focused agenda for such evaluation research.

The UNAIDS *Strategy for Intensifying Prevention* aims to offer a clarion call to all stakeholders, existing and potential, to review their ongoing work and scale up and re-focus it where needed, to view HIV prevention from an operational lens. The following actions are therefore of primary importance:

- harnessing existing and ***new resources*** and enhancing new ways of using funds;
- building ***synergies*** between HIV prevention and treatment;
- developing a ***results-based*** focus in HIV prevention;
- enhancing human, institutional and community ***capacity*** to deliver and manage comprehensive HIV prevention and treatment programmes;
- ensuring ***coordination*** among all players in line with the "Three Ones" principles;
- developing a ***comprehensive*** response to HIV prevention towards reducing risk, vulnerability and impact;
- strengthening evidence-informed HIV-prevention programming and strengthening the ***empirical base*** for action;
- building a *vocal* ***constituency*** of divergent players for HIV prevention; and
- promoting the engagement and ***involvement of people living with HIV***

In the months following the December 2004 Programme Coordinating Board meeting, the UNAIDS Secretariat will work closely with its Cosponsors to develop the concrete actions it will take in keeping with its five strategic functions of leadership and advocacy, strategic information, partnership, resource mobilization, and monitoring and evaluation.

UNAIDS will also participate in and encourage among other stakeholders, reviews of HIV prevention portfolios from the standpoint of the above proposed actions. To ensure national ownership and leadership, plans for implementation will need to be developed at country and regional levels in full consultation with national and regional partners, and in keeping with the realities of local epidemics. UNAIDS will catalyse the development of these plans, drawing on principles of inclusiveness and best practice.

# Annex 1

## UNGASS Declaration of Commitment

Paragraph

7. Acknowledging that prevention of HIV infection must be the mainstay of the national, regional and international response to the epidemic; and that prevention, care, support and treatment for those infected and affected by HIV/AIDS are mutually reinforcing elements of an effective response and must be integrated in a comprehensive approach to combat the epidemic;

### Prevention

Prevention must be the mainstay of our response

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, and to intensify efforts to achieve these targets as well as to challenge gender stereotypes and attitudes, and gender inequalities in relation to HIV/AIDS, encouraging the active involvement of men and boys;
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 for new infection;
49. By 2005, strengthen the response to HIV/AIDS in the world of work by establishing and implementing prevention and care programmes in public, private and informal work sectors and take measures to provide a supportive workplace environment for people living with HIV/AIDS;
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, including the provision of information on health and social services;
51. By 2003, implement universal precautions in health-care settings to prevent transmission of HIV infection;
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 counseling and testing; safe blood supplies; and early and effective treatment of sexually transmittable infections;

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 youth, parents, families, educators and health-care providers;

54. By 2005, reduce the proportion of infants infected with HIV by 20 per cent, and by 50 per cent by 2010, by: ensuring that 80 per cent of pregnant women accessing antenatal care have information, counselling and other HIV prevention services available to them, increasing the availability of and by providing access for HIV-infected women and babies to effective treatment to reduce mother-to-child transmission of HIV, as well as through effective interventions for HIV-infected women, including voluntary and confidential counselling and testing, access to treatment, especially antiretroviral therapy and, where appropriate, breast milk substitutes and the provision of a continuum of care;

# Annex 2

## UNGASS *Declaration of Commitment*

### Measuring progress toward the achievement of the year 2005 targets

In September 2003, UNAIDS published the first *Progress Report on the Global Response to the HIV/AIDS Epidemic, 2003* and summarized available evidence on core indicators developed to monitor implementation of the *Declaration of Commitment*. While the *Declaration of Commitment* called for critical policy frameworks to be in place by 2003 to guide the response to HIV, the first 'hard targets' in the *Declaration* are due to be reached at the end of 2005. Additional non-quantifiable targets focus on implementing an array of measures to address the epidemic's gender dimensions, making significant progress on implementation of comprehensive care strategies, and implementing national policies and strategies to provide a supportive environment for orphans and other vulnerable children.

Since the adoption of the *Declaration of Commitment*, the global response has grown stronger, as measured by the level of financial resources, political leadership and multisectoral commitment. These advances, however, have yet to result in widespread coverage for key prevention measures, including significant increases in knowledge and awareness among young people, and a reduction in the number of new HIV infections. At present, many countries run the risk of failing to achieve the *Declaration's* targets for 2005. Coverage and policy surveys that were conducted in 2004 show that we still have a long way to go. Senior political leaders remain disengaged, especially in countries where prevalence is currently low. Nearly one third of countries lack policies to ensure women's equal access to critical prevention-and-care services. Prevention of mother-to-child transmission services achieved 10% coverage worldwide in 2003, reaching an estimated 9 million pregnant women. In Africa, however, where most cases of mother-to-child transmission occur, coverage was only 5%. While utilization of voluntary counselling and testing has grown 42% over levels reported in 2001, the percentage of adults who know their HIV status remains extremely low in most countries. In 68% of countries, AIDS education is part of the primary-school curriculum, with coverage climbing to 88% for secondary schools. However, fewer than 30% of young people in most countries have a comprehensive knowledge of HIV and AIDS, leading to the obvious conclusion that the effectiveness and coverage of these prevention efforts must dramatically increase.

As we prepare to measure progress towards the 2005 goals, it has become apparent that there must be significant investments to strengthen country capacity to establish effective monitoring and evaluation systems. In light of country reports, regional workshops and comments received from a variety of stakeholders, there is also a need to improve the already well-established list of core and additional UNGASS indicators, which were developed over three years ago. This revised list should strengthen and simplify UNAIDS' reporting on progress towards the UNGASS goals and targets. These changes included improved monitoring of the quality and implementation of key policies, additional risk reduction and behaviour change indicators, particularly for young people, better disaggregation of service coverage data by gender and sex, and the addition of a blood safety indicator. These suggested revisions were reviewed and approved by the Monitoring and Evaluation Reference Group (MERG) that was convened in Geneva from October 25-26 2004. In revising these indicators, it was agreed that there not be dramatic increase in the number of core indicators; there would

be no changes in the four indicators that are Millennium Development Goals; and only existing indicators and tools would be considered to avoid confusion.

An interim report on progress towards *the Declaration of Commitment* is under preparation for 2005. The report will focus on the five target areas for 2005 (prevention, treatment care and support, resources, human rights, including gender, and orphans) using a limited set of indicators drawn from selected countries in each region. This should help provide the basics for a region by region overview of progress in these key areas.