Joint United Nations Programme on HIV/AIDS
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Follow-up to the 2001 United Nations General Assembly Special Session on HIV/AIDS

Progress Report on the Global Response to the HIV/AIDS Epidemic, 2003

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Acronyms

AIDS	Acquired immunodeficiency syndrome
ANC(s)	Antenatal clinic(s)
API	AIDS Program Effort Index
ART	Antiretroviral therapy
ARV	Antiretroviral
ASEAN	Association of South-East Asian Nations
BSS	Behavioural surveillance surveys
CARICOM	The Caribbean Community
CCM	Country Coordinating Mechanisms
CRIS	Country Response Information System
DHS	Demographic and Health Survey
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
HIV	Human immunodeficiency virus
IATT	Inter-Agency Task Team
IDU(s)	Injecting drug user(s)
IEC	Information, education and communication
ILO	International Labour Organization
ITAC	International HIV Treatment Access Coalition
M&E	Monitoring and Evaluation
MICS	Multiple Indicator Cluster Surveys
MTCT	Mother-to-child transmission
NAC(s)	National AIDS Council(s)
NAP(s)	National AIDS Programme(s)
NCPI	National Composite Policy Index
NGO(s)	Nongovernmental organization(s)
NIDI	Netherlands Interdisciplinary Demographic Institute
NSP	National Strategic Plan
PCB	Programme Coordinating Board
PLWHA	People living with HIV/AIDS
PMTCT	Prevention of mother-to-child transmission
PRSP	Poverty Reduction Strategy Paper
R&D	Research and development
SADC	Southern African Development Community
STI(s)	Sexually transmitted infection(s)
TNC(s)	Transnational Corporations
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNRISD	United Nations Research Institute for Social Development
UNDAF	United Nations Development Assistance Framework
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session
UNICEF	United Nations Children's Fund
UNODC	United Nations Office on Drugs and Crime
USAID	United States Agency for International Development
VCT	Voluntary counselling and testing
WHO	World Health Organization

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We wish to express our gratitude to members of National AIDS Councils, AIDS Control Programmes, UN staff and representatives of community organizations, for their generous contribution to this progress report.

Preface

In 2003, the world has a greater opportunity than ever before to alter the course of the global HIV epidemic. As this report indicates, the level of resources available for HIV/AIDS programmes has risen dramatically, and virtually every heavily affected country now has a multisectoral strategic plan of action to address the epidemic. In particular, there is enormous global momentum to expand access to HIV/AIDS treatments in developing countries – a prospect that not many would have predicted only a few years ago.

Yet this report also underscores the challenges that face us. Despite a wealth of information on proven interventions, HIV prevention coverage is extremely low. Fundamental prevention interventions, such as access to voluntary HIV counselling and testing, are only available to one in nine individuals in developing countries and less than one in twenty pregnant women are able to access services to prevent mother-to-child transmission of the virus. A 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. In sub-Saharan Africa, where more than 4 million people could immediately benefit from antiretroviral therapy, only about 50,000 (or about 1% of those in need) currently have access to such medications.

The Declaration of Commitment on HIV/AIDS, adopted at the groundbreaking Special Session of the United Nations General Assembly on HIV/AIDS, reflects the critical importance of accurate information. The 189 Member States that endorsed the Declaration of Commitment meant to do more than produce a wish list of favoured policies. Rather, by making the targets in the Declaration concrete and time-bound and by requiring that unprecedented efforts be undertaken to measure global success in reaching these targets, the Member States envisioned that the Declaration would become an unprecedented tool to promote greater accountability and an outcome-driven sense of urgency and solidarity in the fight against the epidemic.

Using the mandates of the Declaration of Commitment, the UNAIDS Secretariat and Cosponsors collaboratively developed a series of global/regional and national indicators to measure the global community's progress in reaching the Declaration's targets in line with the Millennium Development Goals. This report, which presents data from the first use of these indicators, represents the most comprehensive assessment to date of the state of global, regional and national responses on the broad range of challenges posed by HIV/AIDS. The next global report is due in two years – in 2005. It is our hope that policy-makers, donors, national authorities, advocates, journalists, and concerned individuals throughout the world will find this effort useful, and that the report will help generate even greater commitment to achieving the targets agreed to at the UN Special Session in 2001. The needs are urgent and clear. The critical information provided here will enable us to objectively measure our progress and ensure that we are held accountable for the results.

Dr Peter Piot
Executive Director
Joint United Nations Programme on HIV/AIDS

Introduction

At the close of the groundbreaking Special Session on HIV/AIDS of the United Nations General Assembly, 189 Member States adopted the Declaration of Commitment on HIV/AIDS. The Declaration of Commitment reflects global consensus on a comprehensive framework for effective action to achieve the Millennium Development Goal of halting and beginning to reverse the epidemic by 2015.

Recognizing the need for multisectoral action on a range of fronts, the Declaration of Commitment addresses global, regional and country-level responses to prevent new HIV infections, expand health-care access, and mitigate the epidemic's impact. Although it was governments that initially endorsed the Declaration of Commitment, the document's vision extends far beyond the governmental sector – to private industry and labour groups, faith-based organizations, NGOs and other civil society entities, and organizations of people living with HIV/AIDS. Since its adoption in 2001, the Declaration of Commitment is increasingly recognized worldwide as a central tool for advocacy and accountability.

As defined in the Declaration of Commitment, success in the fight against AIDS is measured by the achievement of concrete, time-bound targets. The Declaration provides for careful monitoring of progress in implementing the agreed-on commitments, requiring the United Nations Secretary-General Kofi Annan to issue annual progress reports that identify problems and constraints and that recommend action needed to accelerate realization of the Declaration's time-bound targets.

In keeping with these mandates, the UNAIDS Secretariat collaborated in 2002 with UNAIDS Cosponsors and other partners in the development of a series of core and additional indicators to measure progress in implementing the Declaration of Commitment. Over the last year, the UNAIDS Monitoring and Evaluation Unit has worked with countries and other actors to collect data needed to establish both monitoring baselines for each indicator and mechanisms for collecting information on an ongoing basis.

The core indicators are grouped into four broad categories:

- A series of global-level indicators are designed to measure ***global commitment and action.***
- Another set of indicators monitors ***national commitment and action*** by tracking domestic government spending on HIV/AIDS and by assessing country-level policy development and implementation against a 20-item National Composite Policy Index.
- ***National programme and behaviour*** indicators measure the percentage of eligible individuals who receive key services and the degree to which particular populations adopt safer behaviours to reduce the risk of HIV transmission.
- ***National impact*** indicators track the number of new infections among young people (aged 15–24) and infants born to HIV-infected mothers.

UNAIDS undertook the collection and analysis of data pertaining to the five global indicators (see Section I), with the assistance of the United Nations Research Institute for Social Development (UNRISD), the International Labour Organization (ILO) and the New Academy of Business, which conducted surveys that were used to address Global Indicators 3 and 4

on workplace policies. Information relating to the other three global indicators was generated primarily by the UNAIDS Secretariat.

In order to make an assessment of the various national indicators, UNAIDS examined national reports submitted to UNAIDS upon request from the Secretary-General to 189 Member States. Of the 189 Member States that received the Secretary-General's request, 103 submitted national reports, including 29 from sub-Saharan Africa, 17 from Asia and the Pacific, 21 from Latin America and the Caribbean, 14 from Eastern Europe and Central Asia, 8 from North Africa and the Middle East, and 14 from high-income countries (see Annex 2). In the majority of cases, the National AIDS Committees or equivalent bodies oversaw compilation of the National Report, and more than three-quarters included the input of three or more government ministries.

UNAIDS guidelines strongly recommended that countries organize one or more broad consultation forums prior to submitting national responses in order to involve civil society organizations and the private sector. Information supplied by countries documents the involvement of civil society in roughly two-thirds of country reports. Country reports also reveal the involvement of people living with HIV/AIDS in 53% of reports submitted.

Nearly all of the countries completed the National Composite Policy Index questionnaire. Only 40% of the countries that submitted reports, however, supplied information relating to the national programme and behaviour indicators or to the national impact indicators.

An important limitation to such data collection is the uneven level of reporting between regions, with the highest proportion of responding countries per region coming from sub-Saharan Africa and the lowest level of reporting from countries in North Africa and the Middle East. Furthermore, some countries tended to provide more extensive information on the national programme and behaviour indicators, while others provided little or no information in this area, making regional comparisons difficult. However, examples given in country reports have been used to illustrate areas in which countries have made progress or have undertaken special activities, wherever possible. Country data presented in this report have been reviewed by UNAIDS and compared with other sources to consolidate validity. National data presented in national reports, however, derive solely from information provided by the countries themselves and UNAIDS does not warrant that the information contained is complete and correct.

This report – the first of what will become regular reports by UNAIDS on the state of the global response – is the most comprehensive assessment to date of national responses to HIV/AIDS. The report is intended to be read as a more detailed companion to the ***Report of the Secretary-General on progress towards implementation of the Declaration of Commitment on HIV/AIDS***, submitted to the General Assembly in September 2003.

Key findings

UNAIDS has monitored progress towards implementation of the Declaration of Commitment, yielding the following key findings:

- ***International and domestic spending***. Spending on HIV/AIDS programmes in low- and middle-income countries will amount to US$4.7 billion in 2003 – a 20% increase over 2002 and 500% increase over 1996. Increases have come both from international donors and from affected countries themselves. UNAIDS estimates that total domestic government spending on HIV/AIDS programmes in 2002 by 58 low- and middle-income countries equaled approximately US$995 million – a doubling of the amount documented in 1999. Despite this important progress, however, current spending is less than half of what will be needed by 2005 and less than one-third of needed amounts in 2007.

- ***Funding for research and development of vaccines and microbicides***. UNAIDS/ World Health Organization (WHO) estimates that public sector spending on HIV vaccine research and development amounted to US$430–US$470 million in 2001, with the United States National Institutes of Health accounting for 57-63% of global spending. Also, the US Government invested US$62 million in microbicide research and development in 2001 – a figure expected to rise to US$214 million in 2003.

- ***Advocacy and leadership***. Monitoring of the media suggests that public awareness of HIV/AIDS is increasing in many parts of the world, including regions where the epidemic is now emerging as a serious problem, such as Eastern Europe and Central Asia. There is also evidence that advocacy efforts are succeeding in many countries in motivating governments to adopt policy reforms to strengthen the response to the epidemic. Nevertheless, monitoring indicates that senior political leaders in many countries, especially those where the HIV epidemic is low and concentrated, remain detached from the fight against the epidemic.

- ***National policy frameworks***. Recent years have seen a significant increase in the number of countries that have comprehensive, multisectoral national HIV/AIDS strategies, as well as government-led national bodies to coordinate the response to the epidemic. By 2003, virtually all heavily-affected countries had policy frameworks in place to mount an effective response to HIV/AIDS. However, numerous countries report that, notwithstanding the existence of multisectoral strategies, the response to the epidemic often remains concentrated in the health sector, with limited collaboration among the full range of ministries that must become actively engaged in the fight against the epidemic.

- ***Weaknesses in national HIV/AIDS policies***. Despite the important progress in developing national strategic frameworks for an effective response, numerous countries risk falling short of the Declaration of Commitment's 2003 policy targets due to critical weaknesses in national efforts. Of particular concern are the following:

  — ***HIV discrimination***. Thirty-eight per cent of countries, including almost one-half of those in sub-Saharan Africa, have yet to adopt legislation to prevent discrimination against people living with HIV/AIDS.

- — ***Vulnerable populations***. Only 36% of countries have legal measures in place to prohibit discrimination against populations that are especially vulnerable to HIV/AIDS.
- — ***Addressing the gender dimensions of the HIV epidemic***. The epidemic's burden on women and girls continues to grow. As of December 2002, women accounted for 50% of all people living with HIV/AIDS worldwide and for 58% in sub-Saharan Africa. Even though numerous and well-documented inequities contribute to the vulnerability of women and girls, nearly one-third of countries lack policies that ensure women's equal access to critical prevention and care services.
- — ***Cross-border migration***. Even though population migration often increases vulnerability to HIV/AIDS, less than one-half of countries have adopted strategies to promote effective HIV-prevention measures for cross-border migrants.
- — ***Access to medications***. On average, 80% of responding countries reported having a policy in place to ensure or improve access to HIV-related drugs. However, for the Asia-Pacific region, where more than 7 million people are currently living with HIV/AIDS, more than one-third of countries have not yet adopted policies to promote access to HIV-related medications, including antiretroviral drugs.
- — ***Mitigation of epidemic's socioeconomic impact***. More than 40% of countries with generalized epidemics (i.e., greater than 1% HIV prevalence in the general population) have yet to evaluate the socioeconomic impact of HIV/AIDS, impeding essential efforts to mitigate the epidemic's impact on society.

■ ***Effectiveness of national policies***. Complementing the findings of the Composite Policy Index, a qualitative study (called the AIDS Programme Effort Index), conducted in 54 countries in 2003, suggests that Africa and Asia do relatively well on political support and policy formulation, and all regions show evidence of improvement with respect to HIV prevention. African countries are more likely to prioritize efforts to mitigate the epidemic's impact than countries in other regions, where the epidemic is less severe. Weakest areas of national efforts are resources, human rights and care.

■ ***Extremely low HIV-prevention coverage***. While most countries have developed strategic frameworks for effective action, only a fraction of people at risk of contracting HIV have meaningful access to basic prevention services.

- — ***Life-skills-based education***. Of the 30 countries reporting on this indicator, half are making efforts to incorporate a life-skills approach into their educational programmes. With evidence that skills-based sexual and reproductive health education promotes healthy lifestyles and reduces risky behaviour, additional countries are in the process of integrating such an approach into their school curricula.
- — ***Basic HIV/AIDS knowledge***. Accurate information about HIV/AIDS is a prerequisite to effective HIV prevention. In 31 of 38 countries in which young women (aged 15-24) were surveyed on basic HIV/AIDS facts in 2000, however, fewer than 30% of women could accurately answer questions on HIV transmission.

- — ***Risk reduction behaviour among young people***. Survey results indicate that condom use with non-regular partners is higher in urban than rural areas and higher among young men than among young women. Young men, however, are more likely to report having had higher-risk sex (i.e., sex with a non-marital, non-cohabiting partner) in the prior year. Data also suggest that condom use varies considerably between countries, with scores ranging from as low as 2% to as high as 88% in Sub-Saharan Africa. In this region, between 15% and 20% of young people report having had sexual intercourse before the age of 15, with young women reporting earlier median age of first sex than do males.
- — ***Sexually transmitted infection management***. Because untreated sexually transmitted infections (STIs) increase the risk of HIV transmission by several orders of magnitude, STI control is a fundamental element of effective HIV prevention. Yet from the limited information received, only one in four countries in sub-Saharan Africa report that at least 50% of STI patients are appropriately diagnosed, counselled and treated.
- — ***Prevention of mother-to-child transmission (PMTCT)***. Four years after research indicated that a relatively inexpensive single dose of nevirapine to mother and newborn significantly reduced the odds of HIV transmission to the infant, PMTCT coverage remains virtually non-existent in many heavily affected countries. Apart from Botswana, where coverage reached 34% by the end of December 2002, PMTCT is extremely low in the countries hit hardest by HIV/AIDS throughout the world.
- — ***Injecting drug use coverage and safer behaviour***. The limited information obtained from countries where injecting drug use is an established mode of HIV transmission reveals that fewer than 5% of injecting drug users (IDUs) receive recommended prevention services. Perhaps as a result of such limited access to prevention services, a majority of drug users have yet to adopt behaviour that will reduce the risk of transmission.

- ■ ***Extremely low antiretroviral therapy coverage***. While an estimated 5–6 million people currently need antiretroviral therapy (ART) in low- and middle-income countries, only 300,000 people in these regions were obtaining such therapy as of December 2002. Although coverage remains low in sub-Saharan Africa, some countries, such as Botswana, Cameroon, Nigeria and Uganda, have made serious efforts to increase ART coverage through both the public and private sectors. Caribbean countries that provided information to UNAIDS report coverage below 1%. In Asia, where more than 7 million people are living with HIV/AIDS, no country has exceeded 5% ART coverage, with several countries reporting particularly low rates.

- ■ ***Children orphaned or made vulnerable by AIDS***. Thirty-nine per cent of countries with generalized HIV epidemics have no national policy in place to provide essential support to children orphaned or made vulnerable by HIV/AIDS. While four countries are in the process of developing such policies, one-quarter of countries with generalized epidemics reportedly have no plans at present to develop such strategies. With the number of children orphaned by AIDS projected to rise to at least 25 million by 2010, there is an urgent global necessity to develop and implement strategies to promote education for vulnerable children, provide critical psychosocial support, and protect them from violence, discrimination and abuse. However, data on orphan school attendance in sub-Saharan Africa suggest strong commitment on the part of some

countries to assist vulnerable children: the ratio of current school attendance among orphans to that among non-orphans is almost 1:1 in half the countries surveyed.

- ***Addressing gender dimensions of the HIV epidemic.*** The epidemic's burden on women and girls continues to grow. As of December 2002, women accounted for 50% of all people living with HIV/AIDS worldwide and for 58% in sub-Saharan Africa. Even though numerous and well-documented inequities contribute to the vulnerability of women and girls, nearly one-third of countries lack policies that ensure women's equal access to critical prevention and care services.

- ***HIV/AIDS in the workplace***. While the engagement of the business community in the response to the epidemic became significantly stronger during 2002, most transnational companies do not regard HIV/AIDS as a serious corporate problem, and few have adopted the comprehensive workplace policies envisioned by the Declaration of Commitment. Integration of HIV/AIDS into workplace policies among NGOs is also uneven. Although UN agencies are more likely than NGOs to provide HIV treatments and other services to HIV-positive staff, additional efforts are needed to implement recommended practices in UN work settings.

- ***HIV prevalence among youth, high-risk groups and newborns***. Country data indicate that the epidemic continues to grow in all parts of the world, with sub-Saharan Africa remaining the hardest-hit region.

  The epidemic remains most severe in Southern Africa, with extremely high HIV prevalence rates among pregnant women aged 15-24 reported in a number of countries, such as ***Swaziland*** (39%), ***Botswana*** (32%), ***South Africa*** (24%), ***Kenya*** (22%), ***Namibia*** (18%), ***Zimbabwe*** (18%) and ***Malawi*** (18%). In ***East Africa***, prevalence in this population continues to decline in ***Uganda***—from 30% in the early 1990s to 9% in 2002. In West and Central Africa, national prevalence rates remain relatively low, although there is evidence of recent HIV spread in countries such as ***Cameroon*** (12%).

  The epidemic in Latin America and the Caribbean is well established. A total of 12 countries in the region have an ***estimated*** HIV prevalence of 1% or more among pregnant women. In other regions, national prevalence is relatively low, as the epidemic is mostly concentrated in specific populations. Exceptions to this rule include ***Cambodia***, ***Djibouti***, ***Myanmar*** and ***Thailand***, where rates among pregnant women exceed 1%.

  Among high-risk groups, numerous countries report concentrated epidemics. In Asia, HIV prevalence among IDUs is extremely high in certain parts of ***China*** (40%), ***India*** (68%), ***Indonesia*** (50%), ***Myanmar*** (70%), ***Nepal*** (50%), ***Thailand*** (85%) and ***Viet Nam*** (80%).

  Eastern Europe and Central Asia continue to experience the fastest-growing epidemic in the world, mainly localized among injecting drug users. The ***Russian Federation*** remains at the forefront of the epidemic with an HIV prevalence among IDUs reaching almost 60% in some areas. However, many other countries in this region are now experiencing rapidly emerging epidemics.

With extremely low coverage for programmes to prevent mother-to-child transmission, rates of HIV transmission to newborns remain high in countries with generalized epidemics. Of the 17 countries in sub-Saharan Africa reporting on PMTCT, 12 have almost no ARV prophylaxis programme, with HIV prevalence among newborns of infected mothers reaching 25%.

- ***Monitoring and evaluation***. Three-quarters of countries reported that monitoring and evaluation (M&E) of national activities remained a major challenge, and countries frequently cited their limited capacity for monitoring and evaluation as impeding their ability to provide information relevant to the national indicators. Only 43% of countries reported having a national M&E plan and only 24% reported having a national M&E budget to carry out these activities.

Global Commitment and Action Indicators

National Commitment and Action Indicators

National Programme and Behaviour Indicators

National Impact Indicators

I. Global Commitment and Action Indicators

1. **Amount of funds spent by international donors on HIV/AIDS in developing countries and countries in transition**
2. **Amount of public funds available for research and development of vaccines and microbicides**
3. **Percentage of transnational companies that are present in developing countries and that have HIV/AIDS workplace policies and programmes**
4. **Percentage of international organizations that have HIV/AIDS workplace policies and programmes**
5. **Assessment of HIV/AIDS advocacy efforts**

The Declaration of Commitment affirms that effective action at country level requires strong and sustained global leadership against the epidemic. The Declaration calls for dramatic, sustained increases in resources to support HIV/AIDS programmes; high-level advocacy to build leadership and commitment; substantially greater cross-country collaboration on HIV/AIDS and improved coordination of regional efforts; and integration of sound workplace policies in the operations of transnational companies and international organizations.

For each of the five global indicators, UNAIDS has adopted a tailored approach to monitor progress towards implementation of the global provisions of the Declaration of Commitment. As explained below, monitoring efforts by UNAIDS have tracked a substantial increase in resources for HIV/AIDS programmes in developing countries, as well as growing public awareness of the epidemic in countries where the epidemic is now emerging as a major problem. Current resources, however, fall substantially short of amounts needed to mount a comprehensive fight against HIV/AIDS, and key sectors, such as the world of work, remain underutilized in the global response.

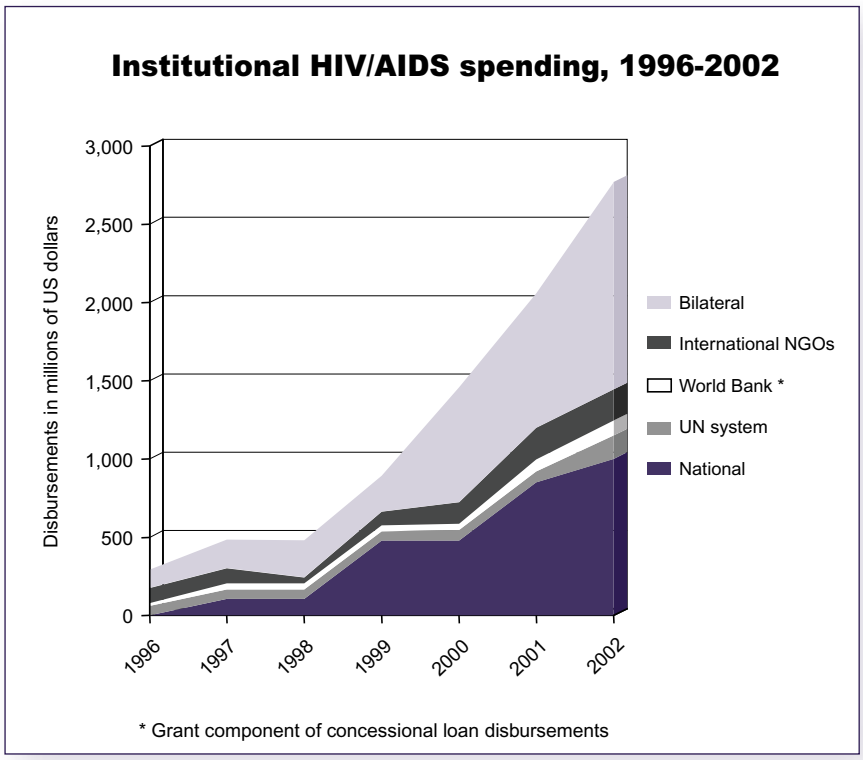
1. International funding for HIV/AIDS

Amount of funds spent by international donors on HIV/AIDS in developing countries and countries in transition

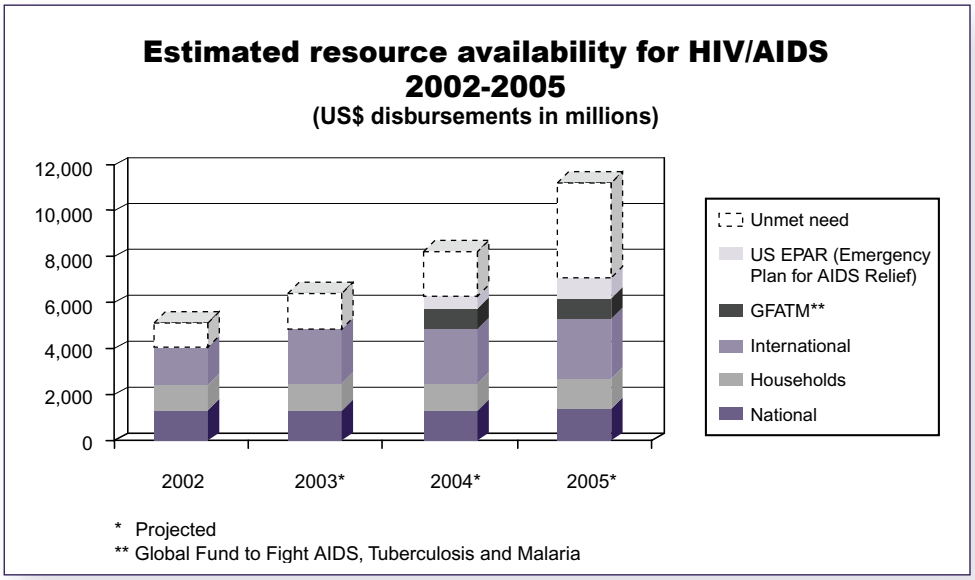
Beginning in 2002, UNAIDS significantly enhanced its capacity to track resources available for HIV/AIDS programmes in low- and middle-income countries. This effort excludes funds that have been pledged but not yet approved, as well as resources that have been committed but not yet disbursed.

Due to the relative newness of this area of work, gaps remain in the Programme's ability to monitor resource flows with optimal precision. It is anticipated that ongoing improvements

in resource-tracking methodologies will significantly improve the ability to capture relevant spending data in a timely manner.

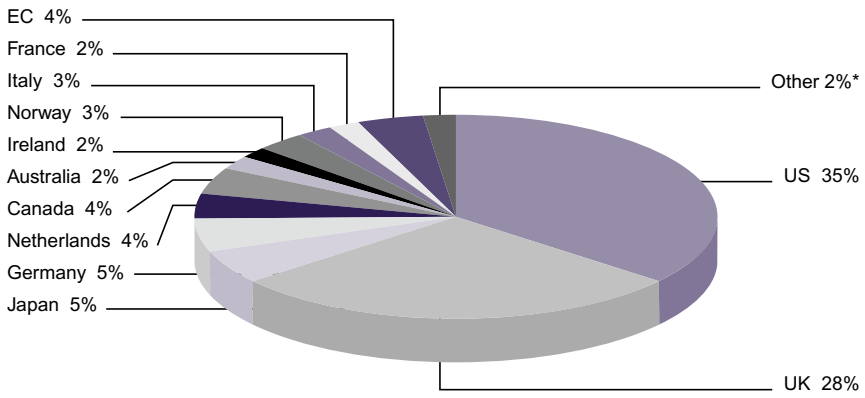


Based on the best available information, UNAIDS estimates that spending on HIV/AIDS in low- and middle-income countries will amount to US$4.7 billion in 2003. This represents a 20% increase over 2002 spending (US$3.9 billion) and an almost 500% increase over 1996 spending.



Non-domestic sources are expected to account for roughly 57% of spending on HIV/AIDS programmes in low- and middle-income countries in 2003. International spending in 2003 includes a projected US$1.6 billion in bilateral assistance and US$600 million in multilateral spending (including the Global Fund). Between 1996 and 2002, non-domestic HIV/AIDS assistance (bilaterals, European Commission, international foundations, NGOs, UN system, and World Bank loans) increased roughly sixfold – from US$297 million to nearly US$1.8 billion – and this amount is projected to increase by almost 40% in 2003 to US$2.5 billion.

Percent distribution of bilateral spending on HIV/AIDS programmes among high-income countries, in 2003



* Development Assistance Committee of the Organization for Economic Cooperation and Development (OECD)

Bilateral budgets and projected disbursements on HIV/AIDS programmes for selected high-income countries and the European Commission, in 2003

	Budgeted US$ in millions	Projected disbursemements US$ in millions
US	838.3	576.8
UK	408	452.1
Germany	133.7	107.1
Japan	95	85
Canada	93.8	66.3
EC	93.2	65
Netherlands	82	65
Norway	50.8	50.8
Ireland	44.9	40
Australia	39	39
Italy	36.4	25.0
France	36.3	25.0
Other	49.5	40
TOTAL	2,000.9	1,637.1

Sub-Saharan Africa has received the largest share of international financial assistance – 56% of amounts disbursed by selected donor countries in 2000, the most recent year for which regional estimates are available. Asia and the Pacific account for the next largest share (18%), followed by Western Asia and North Africa (9%), Latin America and the Caribbean (9%), and Eastern Europe (1%). Global and inter-regional spending consumed 19% of HIV-focused development assistance in 2000.

Financial resources for HIV/AIDS – promising developments in 2003

Over the last year, important developments have accelerated the mobilization of major new resources for HIV/AIDS. Governments in the US and Europe in 2003 announced their intention to significantly increase spending on HIV/AIDS through both bilateral and multilateral channels. The Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) – an outgrowth itself of momentum created by the Declaration of Commitment – had by June 2003 accrued approximately US$4.6 billion in pledges and approved US$1.5 billion in grants for HIV/AIDS, tuberculosis and malaria interventions in 93 countries. (The degree to which GFATM will contribute to further increases in international HIV/AIDS assistance beyond 2003 remains unclear, as the bulk of current pledges extend over five or more years, limiting amounts currently available for approval of additional country proposals. It is estimated that GFATM requires contributions of at least US$2 billion in 2003 and US$ 4.6 billion in 2004 to meet the anticipated demand from eligible countries.)

Despite recent advances in mobilizing resources for the fight against AIDS, projected 2003 funding nevertheless falls far shy of the sum needed to mount an effective response[1]. UNAIDS estimates that the gap between projected spending in 2003 and estimated programme capacity at country level is US$1.6 billion. Current spending represents less than half of the US$10.7 billion that will be required to finance the comprehensive 25-intervention package in 2005, and less than one-third of the US$14.9 billion that will be needed by 2007.

Assessment of current and future resource gaps stem from UNAIDS-facilitated work by economic experts, as updated in ***Financial Resources for HIV/AIDS Programmes in Low- and Middle-Income Countries over the Next Five Years***, submitted to the UNAIDS Programme Coordinating Board in December 2002[2]. The analytical framework developed by UNAIDS incorporates data on unit costs and current coverage for standard interventions, as well as limitations in programming capacity due to inadequacies of capital infrastructure or human capacity. It is projected that capacity in low- and middle-income countries for HIV prevention, care, treatment, and orphan support interventions will increase from US$4.7 billion in 2002 to US$8.3 billion in 2004, as additional resources and the existence of strategic policy frameworks permit incremental scaling-up at country level.

[1] UNAIDS estimates that 53% of needed expenditures in 2003 should be directed towards prevention services – 40% for care and treatment, and 7% for orphan support activities.

[2] Available on the UNAIDS website at http://www.unaids.org/about/governance/files/PCB_13_02.5_en.doc_

Supporting HIV/AIDS efforts through development assistance

The Declaration recognizes that the response to HIV/AIDS requires not only new spending on HIV-specific programmes but also broader international aid programmes that help countries alleviate the poverty and under-development that increase vulnerability to HIV/AIDS. The Declaration calls on donor countries to meet the agreed-on target of 0.7% of gross national product for overall official development assistance. Denmark currently leads the way in this regard, having allocated 1.03% of GNP in 2001 to official development assistance. Other donor countries that meet or exceed the 0.7% target include Norway (0.83%), Luxembourg (0.82%), the Netherlands (0.82%), and Sweden (0.81%).

2. Public funding for research and development

Amount of public funds available for research and development of vaccines and microbicides

With leading experts cautioning that the rate of new HIV infections could accelerate by 25% or more this decade, the development of new prevention technologies represents an overriding global health priority. Two preventive approaches – vaccines and microbicides – offer hopes for substantially expanding the array of tools available to prevent the spread of HIV.

Unfortunately, the world has been slow to invest in research and development relating to health problems that primarily affect developing countries. Only 10% of the US$70 billion spent each year on biomedical research is devoted to the diseases that represent 90% of the world's health burden.

Vaccines. Although a preventive vaccine offers the best hope for reversing the global epidemic, the search for a safe and effective vaccine confronts numerous obstacles. In addition to the considerable scientific challenges that must be overcome, few major companies have actively pursued HIV vaccine research programmes, and vaccine research has historically accounted for a relatively small fraction of public sector investment in HIV-related biomedical research[3].

- ***First Phase III Trial***. In 2003, VaxGen, a US-based corporation, announced the results of the first Phase III efficacy trial for an HIV vaccine candidate. Conducted in the US and Europe, the trial tested a gp120, clade-B vaccine designed to produce antibodies against HIV. While the trial failed to demonstrate efficacy in preventing infection, it nevertheless underscored the feasibility of conducting Phase III vaccine trials.
- ***Spending on vaccine research and development***. To establish a baseline for future monitoring of vaccine-related spending in all sectors, UNAIDS and WHO surveyed 12 leading public sector or public-private research programmes in 2002 (see box). All 12 programmes responded to the UNAIDS/WHO questionnaire.

[3] At the US National Institutes of Health, the largest funder of HIV-related biomedical research, vaccine research accounts for 11% of its HIV/AIDS research budget.

Leading research programmes surveyed on vaccine R&D spending

- *Agence Nationale de Recherches sur le Sida* (France)
- Centers for Disease Control and Prevention (US)
- National Institutes of Health (US)
- Ethiopia-Netherlands AIDS Research Project (Netherlands)
- EUROVAC (European Community)
- HIV Vaccine Trails Network (US)
- International AIDS Vaccine Initiative
- *Instituto Superiore di Sanità* (Italy)
- National Institute of Infectious Diseases (Japan)
- National Institute of Biological Standards and Control (UK)
- South African AIDS Vaccines Initiative (South Africa)
- Walter Reed Army Institute of Research (US)

On the basis of responses to the survey, UNAIDS/WHO estimates that public sector spending on HIV vaccine research and development amounted to US$430–US$470 million in 2001. The US National Institutes of Health accounted for US$269 million of spending on vaccine-related R&D, or 57-63% of global spending.

Although definitive figures are not available, it is likely that spending on vaccine R&D in 2003 will significantly exceed 2001 levels. NIH reports that its HIV vaccine research expenditures this year will equal US$422 million – a 57% increase over 2001 – and the Bill and Melinda Gates Foundation, the European Commission's Developing Countries Clinical Trial Platform, and other entities are expected to make significant new investments in vaccine research this year.

Microbicides. The shortage of female-controlled prevention tools inhibits efforts to prevent sexual transmission, especially in regions where economic, political and social disabilities make it difficult for women to negotiate condom use with their sexual partners. Development of effective prevention strategies that women themselves can control represents a critical global priority.

- ***Private philanthropic support***. In recent years, substantially greater research attention has been paid to efforts to develop one or more safe and effective microbicides for the prevention of HIV and other STIs. In 2002, the Rockefeller Foundation launched the International Partnership for Microbicides, which, by March 2003, had attracted more than US$100 million in contributions, including a five-year grant of more than US$60 million from the Bill and Melinda Gates Foundation.

- ***Research momentum***. Public sector and philanthropic support for microbicide research is especially important given the fact that no major pharmaceutical company has yet to become involved in microbicide R&D. Despite the failure of market incentives to encourage private sector investment in microbicides, six candidate microbicides are being prepared in 2003 for large efficacy trials.
- ***Funding gap***. The Rockefeller Foundation estimates that US$775 million will be needed over the next five years to increase the likelihood of a safe and effective microbicide being generated by 2010[4]. In the fiscal year ending in 2001, the US Government invested US$62 million in microbicide R&D – a figure that is expected to rise to US$214 million in 2003.

Increasing resources for HIV/AIDS research: The Bill and Melinda Gates Foundation

The Bill and Melinda Gates Foundation has taken important leadership in strengthening global commitment to research and development on HIV/AIDS vaccines and microbicides. The foundation has contributed more than US$126 million to the International AIDS Vaccine Initiative to accelerate the development and clinical evaluation of promising vaccine candidates. In 2003, senior foundation officials joined with HIV/AIDS research experts to propose the creation of a global HIV vaccine enterprise to strengthen, accelerate and strategically coordinate diverse efforts to study potential avenues for HIV vaccination. A US$20 million grant by the Gates Foundation is helping to underwrite Phase III testing of Carraguard, a leading microbicide candidate, and the foundation has made a separate multi-year grant of US$60 million to the International Partnership for Microbicides.

3. Workplace HIV/AIDS control in transnational companies

Percentage of transnational companies that are present in developing countries and that have HIV/AIDS workplace policies and programmes

The HIV epidemic is adversely affecting industry in many parts of the world, especially in sub-Saharan Africa, contributing to loss of labour, skills and experience, increasing absenteeism, and burdening companies with additional costs for health care, pension payouts, and worker training. AngloGold, a subsidiary of Anglo-American, calculates that nearly one-quarter of its 90,000 gold-and-diamond-mining workers are infected with HIV and that AIDS costs the company up to US$6 for every ounce of gold produced. As affirmed by the Declaration of Commitment, effective action by industry is needed to mitigate the epidemic's long-term impact on economic growth.

The workplace plays a potentially critical role in strengthening HIV prevention, care and support initiatives. As recognized in the ILO ***Code of Practice on HIV/AIDS and the World of Work***, the workplace offers numerous opportunities for increasing AIDS awareness,

[4] http://www.global-campaign.org/fundingneeds.htm. This pharmaco-economics study, commissioned by the Rockefeller Foundation, does not include the costs of: research to discover new leads; work on the introduction of, and access to, new products; organizational overhead; and advocacy efforts.

delivering HIV prevention services, and expanding coverage for health and support services. A recent study in Zimbabwe, for example, found that workers in factories with peer-based HIV-prevention programmes had infection rates 34% lower than comparable workplaces without such programmes. Studies have determined that the costs to companies of treatment and care programmes are outweighed by the benefits of keeping workers healthy and productive.

In recent years, the business community has begun to mobilize against the epidemic. The Global Business Coalition on HIV/AIDS, which now has more than 100 international corporate members, seeks to encourage corporate involvement in the fight against AIDS, often working in partnership with national business councils, such as the South African Business Coalition on HIV/AIDS. With more than 50 member companies, the Global Health Initiative of the World Economic Forum aims to "foster greater private sector engagement in the global battle against HIV/AIDS, tuberculosis (TB) and malaria".

Using the ILO ***Code of Practice*** as a guide, UNAIDS determined that sound HIV/AIDS workplace policies among international organizations should include the following minimum components:

- Prevention of stigmatization and discrimination on the basis of HIV-positive status in staff recruitment, promotion, and employment, sickness and termination benefits.
- Workplace coverage that provides:
  - basic facts on HIV/AIDS;
  - information on specific work-related HIV transmission hazards and safeguards;
  - condom promotion;
  - voluntary counselling and testing (VCT);
  - STI diagnosis and treatment; and
  - provision of HIV-related drugs.
- Training for HIV/AIDS control in conflict, emergency and disaster situations, where applicable.

For the purposes of monitoring implementation of the Declaration of Commitment, UNAIDS and UNRISD undertook a survey of the 100 largest transnational companies (TNCs), ranked according to foreign assets, to obtain information on corporate responses to the epidemic. Generalizing these survey results should be done cautiously, since only 30 of the top 100 TNCs responded, but the survey nevertheless generated useful findings.

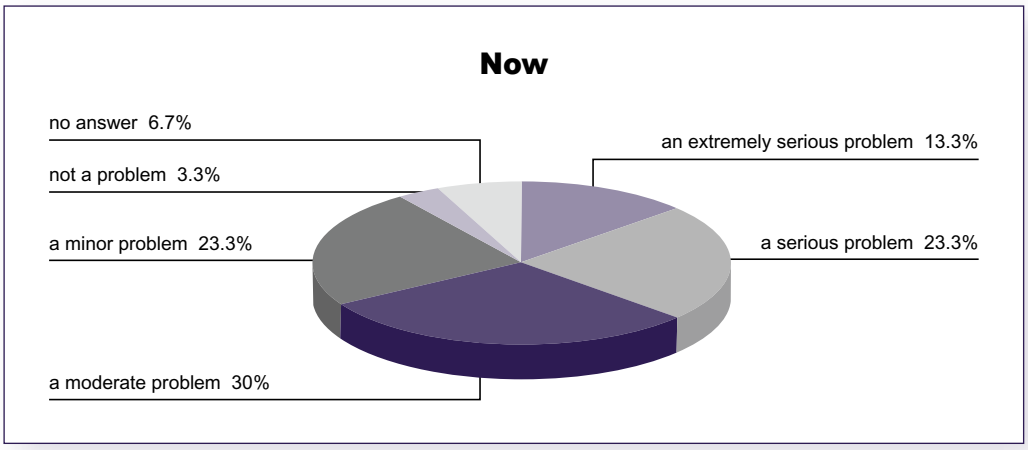
- ***Workplace policies***. Seventy per cent of the 30 reporting companies say they have policies or programmes to address HIV/AIDS in the workplace. Altogether, this number represents 21% of the 100 largest TNCs.

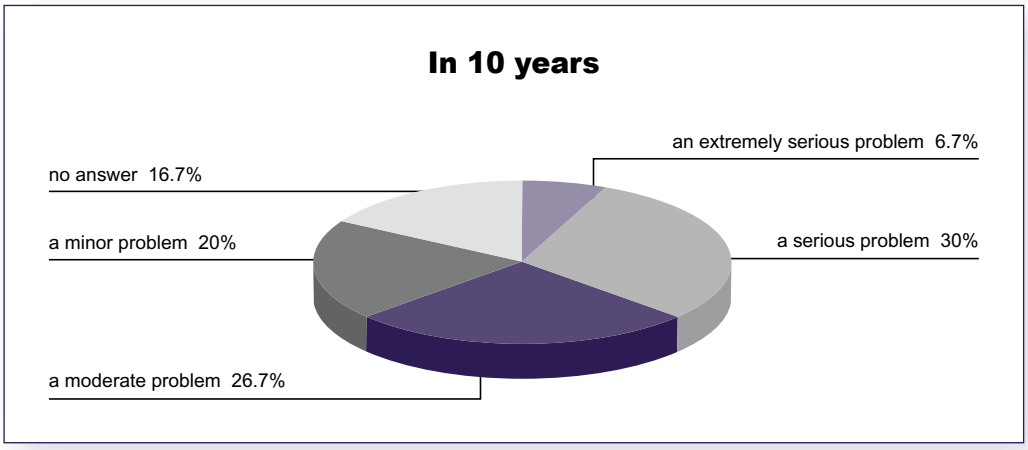
  Subsequent investigation was undertaken to assess the degree of corporate commitment to HIV/AIDS workplace policies. Specifically, UNRISD consulted the websites of the 100 largest TNCs, finding that 39% mentioned HIV/AIDS but that only 11% provided clear information specifically relating to workplace policies or programmes. On the basis of this follow-up investigation, UNAIDS and UNRISD concluded that the above-noted 21% estimate for workplace policy coverage is probably a closer reflection of reality than the 70% positive score for the relatively small number of responding companies.

- ***Perceived impact of HIV/AIDS on company***. It appears that most TNCs do not yet regard HIV/AIDS as a serious problem for their companies. Approximately 57% of respondent TNCs characterized HIV/AIDS at the moment as not being a problem, as being a minor problem or as being a moderate problem, although this percentage declined by 47% when companies were asked to estimate the epidemic's impact on their operations by 2013. Twenty-three per cent said HIV/AIDS is now a serious problem, and 13% said it is an extremely serious problem. Seven per cent gave no answer.

  Perceptions of the epidemic's impact on corporate operations depend greatly on the regions where companies have a presence. Companies with operations in developing countries were substantially more likely to say the epidemic was adversely affecting their operations. Eighty-four of respondent TNCs said the HIV epidemic was having a negative impact on their branches in sub-Saharan Africa.

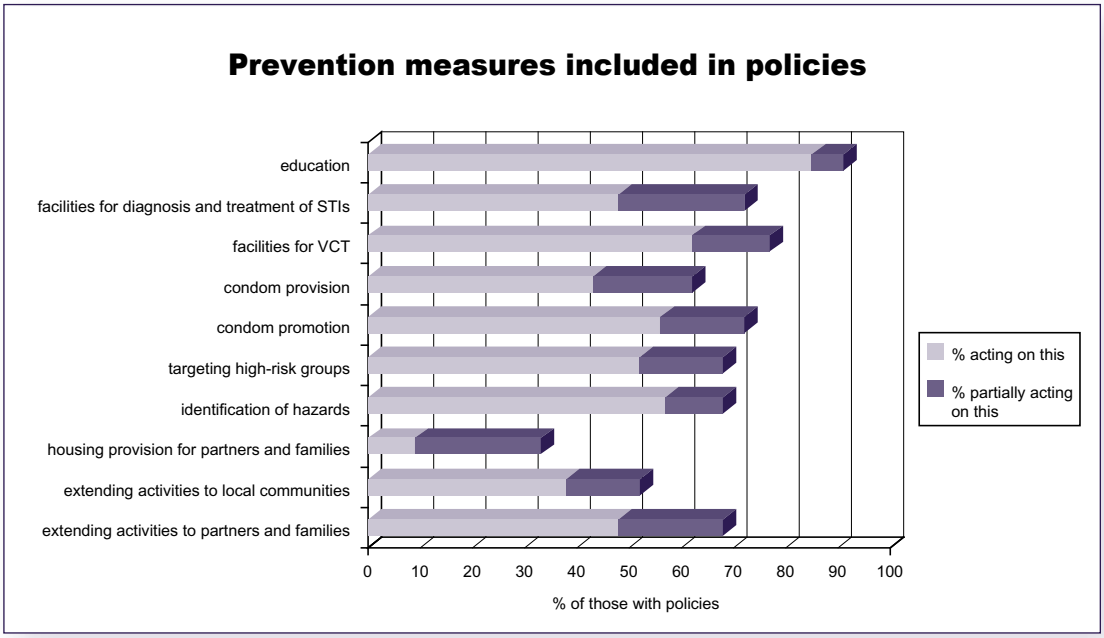
Attitudes of the boards of 30 companies as to the current and future threat of HIV/AIDS on their business





- ***Prevention***. Prevention measures offered by companies to their workers vary significantly. More than 90% of respondent companies with HIV policies indicate they provide HIV/AIDS educational activities, with several indicating they use peer-based approaches. More than 60% say they offer voluntary counselling and testing to their workers, and more than half promote the use of condoms (although only slightly more than 40% actually make condoms available to employees).

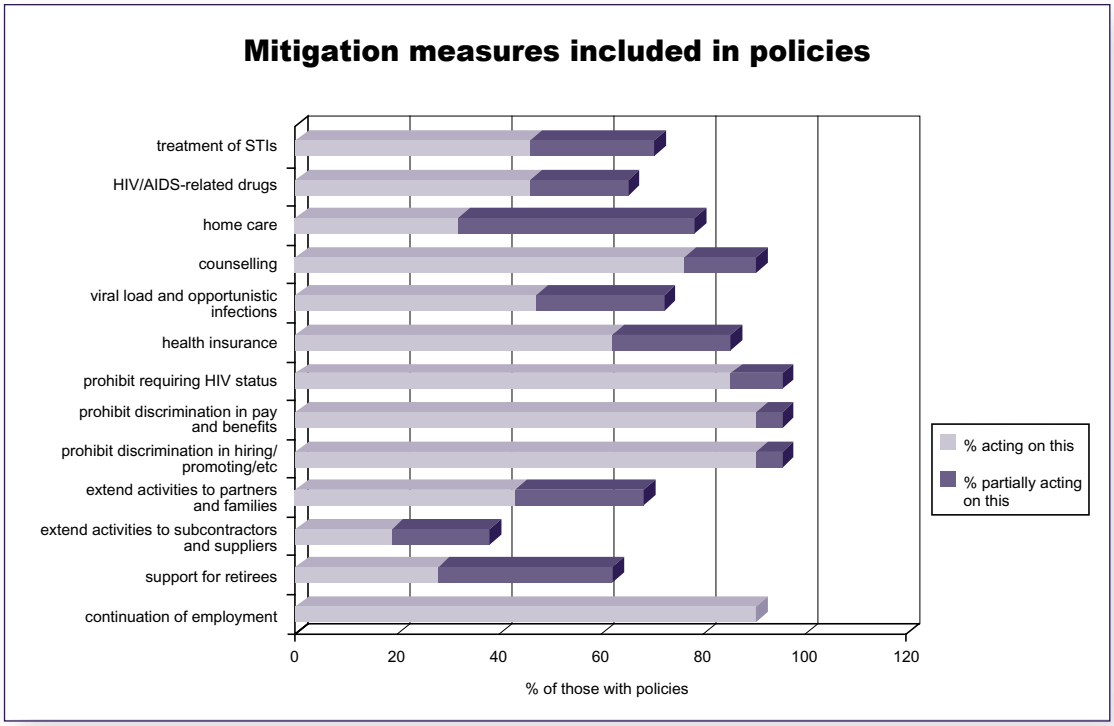
  The degree to which prevention measures are available to workers' partners, families and local communities varies, although most respondents indicate that access to at least some of these programmes extend beyond workers themselves.



- ***Treatment, care and impact mitigation***. More than 60% of respondent companies indicate that they provide some coverage for ART – a notable percentage, given that it was only in recent years that the first companies, such as Heineken and Anglo American, announced they would provide free ART to HIV-positive workers. Health coverage is limited for family members and usually non-existent for subcontractors and suppliers.

  It is unclear from survey results whether company-sponsored health coverage is affordable or comprehensive. Several companies said they work to facilitate workers' access to needed services but often could not guarantee access because such services were either scarce or non-existent.

- ***Anti-discrimination policies***. More than 80% of respondent companies reportedly prohibit discrimination in hiring, pay and benefits. A similar percentage has workplace policies barring management from requiring workers to disclose their HIV status.



4. Workplace HIV/AIDS control in international organizations

Percentage of international organizations that have HIV/AIDS workplace policies and programmes

Survey of international organizations. To assess the workplace policies and programmes of international organizations, the UNAIDS Secretariat commissioned the New Academy of Business to conduct a survey of such groups. In 2003, 182 international organizations received a questionnaire on HIV-related policies, and 43 responded (26 NGOs, 8 UN agencies, and 9 bilateral agencies).

- ***Few workplace policies***. Only 14% of those surveyed have HIV/AIDS policies that adhere to recommended standards (as defined by the ILO Code of Practice). Among responding international organizations, 38% did not feel that their organization needed a specific workplace policy or programme on HIV/AIDS. Fewer than half of surveyed organizations (43%) said that they have a HIV/AIDS workplace policy and programme covering all sections of the organization.

- ***Basic health services***. With respect to specific workplace policies, substantially larger percentages appear to meet the requirements set forth in the ILO Code of Practice. Nearly three-quarters (73%) provide free or affordable facilities for voluntary counselling and testing, and more than 90% offer HIV/AIDS education to staff. All surveyed organizations indicate that they prohibit discrimination in hiring, promotion, transferring and compensation.

- ***HIV/AIDS treatments***. Twenty-one per cent of international organizations surveyed provide their workers with insurance that covers HIV/AIDS treatments. Fewer than one in five (18%) say they provide free home care for staff with HIV-related illnesses (although there were no respondents from the NGO sector). According to survey results, UN agencies are more likely than NGOs to extend coverage to partners, families, local communities, and suppliers.

  Survey results reveal that a substantial proportion (80%) of the international development community has attempted to provide HIV-related drugs at affordable levels. More than 70% of responding organizations are able, at least partially, to "ensure the availability of affordable or free facilities for the treatment of STIs". For HIV drugs and STI treatments, all organizations that responded negatively were from the NGO sector.

Overall, while the large majority of international organizations comply with certain key aspects of recommended workplace policies (such as provision of basic HIV-prevention services or adoption of anti-discrimination policies), few organizations have taken a comprehensive approach to HIV/AIDS in the workplace. Although survey results do not allow for definitive conclusions, certain possible explanations appear plausible. Some NGOs, for example, may lack the means to cover the costs of expensive ART. Likewise, although faith-based organizations may routinely promote AIDS awareness in the workplace, they may refrain from actively promoting the use of condoms; indeed, only 10% of responding organizations indicate that they make condoms available to workers.

Oxfam: addressing HIV/AIDS in the workplace

In June 2001, an organizational audit of Oxfam workplaces in Southern Africa concluded that HIV/AIDS will have profound effects on the organization, including increases in absenteeism and financial costs associated with health benefits, declines in productivity, and loss of institutional capacity. These projections alerted Oxfam senior managers to the need to tackle HIV/AIDS in all spheres of work, including the workplace, leading to a decision to mainstream HIV/AIDS into Oxfam's organizational policies and practices. Oxfam has produced a discrete HIV/AIDS workplace policy for its staff, covering non-discrimination, confidentiality, HIV prevention, ART, and access to care and support. Staff and partners are also encouraged to analyse the likely impact of the epidemic and to adapt their programmes accordingly. For example, the Joint Oxfam International programme in Malawi conducted staff awareness workshops that resulted in the provision of 'condom corners' for the Oxfam offices, the appointment of HIV and AIDS focal persons, and monthly HIV/AIDS information sessions.

HIV/AIDS in the UN workplace. Like any other workplace, the UN must also address the challenge of HIV and AIDS. The UN workforce faces special vulnerabilities stemming from high mobility due to frequent mission travel, periods of adjustment with change of duty stations and absences from family and support networks. In addition, by virtue of its mandate, the UN system is positioned to play an exemplary role in promoting good employment practices with respect to HIV/AIDS.

- ***UN policy on HIV/AIDS in the workplace***. Since 1991, the UN system personnel policy on HIV/AIDS has provided the policy platform for initiatives in the UN workplace. The advent of new international policy developments in the area of HIV/AIDS signaled by the UN Declaration of Commitment on HIV/AIDS and the ILO Code of Practice on HIV/AIDS and the World of Work have provided an opportunity for the UN system to review its response, both in its own workplace and in the context of its wider mandate.

  On 23 September 2002, UN Secretary-General Kofi Annan noted that UN adherence to its own established mandates remained uneven. The Secretary-General directed UN agencies to assess their workplace policies and, where needed, take immediate measures to implement practices that comply with recommended standards.

- ***Survey of UN workforce***. To assess the attitudes and knowledge of the UN workforce on HIV/AIDS, UNAIDS conducted a survey of more than 8000 UN staff (roughly 10% of the entire UN system) from 82 country offices and headquarter locations. The survey revealed the following:

  — 17% of UN staff do not know what HIV/AIDS is;

  — roughly one-quarter (26%) indicate that they understand the basics of HIV/AIDS treatment;

  — 5% are aware that they are HIV-positive but are unwilling to reveal this at work due to fear of job loss or differential treatment;

  — more than 40% say they don't know their HIV status but worry that seeking this information might be perceived negatively;

  — nearly half say they have never received information on HIV/AIDS from the UN, relying instead primarily on the media as their main source of information; and

  — 40% desire additional information on HIV/AIDS.

  Although those who responded to the UNAIDS survey may not be representative of the entire UN workforce, the survey results nevertheless identify areas for potential improvement in UN workplace policies on HIV/AIDS. In particular, survey results have informed UNAIDS' development of a learning strategy on HIV/AIDS, which is currently being implemented.

A separate effort to assess workplace policies in the UN has been spearheaded by the Inter-Agency Task Team (IATT) on HIV/AIDS and the World of Work. The IATT surveyed UN agencies to determine the degree to which their policies and practices complied with those recommended in the ***ILO Code of Practice***. The UN interagency report highlights the fact that, despite some very good practices by some agencies, the UN workplace as a whole has not systematically integrated HIV/AIDS into its human resources planning culture and will need to strengthen its response to the impact of HIV/AIDS on its workforce and organizational capacity.

The United Nations in Kenya: extending access to HIV/AIDS treatment for subcontractors

In July 2003, United Nations agencies based in Nairobi issued new regulations that will require all their contractors to offer their workers HIV/AIDS medical coverage. Contractors must enrol their employees in medical insurance schemes so that the employees can access and receive appropriate treatment for HIV/AIDS.

Although the UN in Nairobi began offering AIDS medication to its 1600 full-time staff in 1992, the new policy will apply to all personnel employed through contractors. The new policy – a first for the UN in Africa – will offer antiretroviral drugs for 400 workers who spend more than half their working week at the UN complex in Nairobi. The workers are employed by 17 subcontractors that offer services in landscaping and gardening, cleaning, electrical works, general building maintenance, travel agency services, catering operations, shipping and forwarding, and courier services.

Over the next year, a number of activities have been identified for action by the UN Human Resources Task Force on HIV/AIDS, including:

1. Promotion of policy and the ***ILO Code of Practice***

Also, a review of the following issues is envisaged: absences, flexible working hours, attendance at funerals, succession planning, and after-service care, with a view to fostering a compassionate UN workplace.

2. Social security benefits

Advocate better benefits for staff with different contractual arrangements.

3. Prevention and awareness-raising

Building HIV/AIDS competence among UN staff through:

- promotion of the learning strategy throughout the UN system
- development of an implementation guide for use by UN agencies and country teams
- training of regional facilitators
- sensitivity training for all managers in each UN agency
- development of an effective communication and marketing strategy to facilitate mainstreaming of HIV/AIDS into workplace policies and practices.

4. Care and support

Enhancing care and support services through:

- an evaluation of current activities in the area of care and support
- identification of best practices
- a feasibility study relating to the provision of free VCT for staff.

5. HIV/AIDS advocacy

Assessment of HIV/AIDS advocacy efforts

Key developments in 2002-2003. The increasing effectiveness of HIV/AIDS advocacy efforts (by NGOs, people living with HIV/AIDS, UN agencies, diplomats, faith-based groups, business leaders, labour organizations, and a wide array of other actors) is reflected in the growth of political commitment and available resources for HIV/AIDS programmes. Over the last 12-18 months, a notable strengthening of AIDS advocacy is apparent on multiple fronts and by diverse actors.

- ***Developed countries***. In developed countries, advocacy groups have been increasingly vocal in calling for substantial increases in international financial support for HIV/AIDS programmes. Joining with their counterparts from developing countries, AIDS advocates in donor countries have demanded the acceleration of efforts to expand treatment access in resource-limited settings. Increasingly, HIV/AIDS has become an important focus of diplomatic dialogue (for example, at such global gatherings as the G-8 summit and the World Economic Forum, and in bilateral diplomatic encounters). In July 2003, a global gathering in Paris (co-chaired by cabinet ministers from the US and France) highlighted the importance of increasing financial support for the GFATM.

- ***Regional leadership***. A growing array of regional bodies are exhibiting stronger and more visible commitment to cooperating in the fight against HIV/AIDS.

  — ***Eastern Europe and Central Asia***. In May 2002, a summit meeting of the Commonwealth of Independent States (CIS) endorsed the Programme of Urgent Response of the CIS Member States to the HIV/AIDS Epidemic, and heads of government have subsequently designated high-level national coordinators with authority over broad multisectoral responses.

  — ***Sub-Saharan Africa***. In a variety of settings (including an unprecedented summit in Abuja in 2000 and under the umbrella of the Southern African Development Community), African leaders have affirmed and strengthened their determination to work together in the fight against HIV/AIDS. AIDS Watch Africa, a group of African Heads of State, is monitoring progress in implementing the 2001 Abuja Declaration. In July 2003, in Maputo, a Global Forum on Health and Development was organized at the African Union Summit, bringing together African Heads of State, UN officals and AIDS experts from around the world. A special Summit of Heads of State and governments of the Southern African Development Community (SADC) was also held in Maseru, Lesotho to address the threat of HIV/AIDS to the region and the required response. African First Ladies are mobilizing to combat HIV/AIDS on the continent, tackling stigma and mother-to-child HIV transmission.

  — ***Asia and the Pacific***. UNAIDS is collaborating with countries in the Asia and Pacific region to implement the programme of action endorsed by the Asia Pacific Leadership Forum on HIV/AIDS and Development, launched in August 2002. Leaders of countries belonging to the Association of South-East Asian Nations (ASEAN) have similarly joined together to promote regional solidarity and cooperation in the fight against HIV/AIDS.

- — ***Caribbean***. Membership in the Pan-Caribbean Partnership against HIV/AIDS, launched in 2001, now includes some 63 institutions, such as UN agencies, regional NGOs, multilateral and bilateral donors, private sector enterprises, and all governments in the region. Regional mobilization against HIV/AIDS has particularly benefited from the personal leadership and commitment of Dr Denzil L. Douglas, Prime Minister of St Kitts & Nevis.
- — ***UN assistance for regional efforts***. The Secretary-General has worked to further strengthen regional advocacy by designating high-level ambassadors as special AIDS envoys to different regions. Special UN envoys on HIV/AIDS are Sir George Alleyne (Caribbean); Prof. Lars Kallings (Eastern Europe and Central Asia); Stephen Lewis (Africa); and Nafis Sadik (Asia).

■ ***Country-level leadership and advocacy***. Advocacy has also yielded important progress in many countries, including those where HIV/AIDS is now emerging as a serious problem. In Indonesia, for example, where HIV infection rates are rising, a special cabinet meeting was held in 2002 to address the epidemic. The President has spoken publicly about the rights of people living with HIV/AIDS, and the country has embarked on a formal five-year HIV/AIDS strategy. Likewise, in India, in July 2003, the Prime Minister welcomed more than 1000 representatives of all levels of government to a national convention of elected representatives to address the growing problem of HIV/AIDS. In China, the first national conference on HIV/AIDS in 2001 helped increase national awareness of the epidemic and strengthen the response of both governmental and nongovernmental sectors.

Assessment of media coverage. By its very nature, the effectiveness of AIDS advocacy is difficult to evaluate. Not only is it challenging to assess effectiveness when advocacy efforts often require many years to achieve the desired outcome, but the diversity of forms that advocacy can take (such as media communications, awareness campaigns, lobbying, and grass-roots mobilization) also makes it difficult to measure success. Because advocacy occurs at all levels in all regions of the world and is undertaken by a host of diverse stakeholders, it would be virtually impossible to assess with precision the collective impact of these efforts.

The UNAIDS Secretariat attempted to evaluate at least one manifestation of advocacy by comparing HIV-related news coverage in October/November 2001 with such coverage in October/November 2002 in 10 selected countries (Brazil, China, Ghana, Honduras, Jamaica, Kazakhstan, Myanmar, Nepal, the Russia Federation and Zimbabwe). The analysis also included AIDS-related statements or declarations by global/regional groupings, such as the African Union, the Caribbean Community (CARICOM), and the International Federation of Red Cross and Red Crescent Societies.

Relying on news articles from the UNAIDS online news archive, the media analysis identified 569 HIV-related articles. The analysis sought to assess prevalent attitudes towards the epidemic in the 10 selected countries, identify coverage trends, and note important gaps or areas of concern.

The analysis detected a sharp increase between 2001 and 2002 in the magnitude of HIV-related coverage and, specifically, in the number of articles advocating HIV/AIDS awareness in China, Ghana, the Russia Federation and Zimbabwe, suggesting that public discussion of the epidemic may be increasing in these countries. In Brazil, Honduras and Kazakhstan, coverage declined during the two years. Jamaica and Myanmar saw modest increases in coverage.

With the exception of ASEAN, the number of HIV-related media statements from regional bodies increased between 2001 and 2002. The drop in ASEAN media coverage on HIV/AIDS (from 11 articles in 2001 to none in 2002) may be explained by the heavy coverage that greeted the November 2001 declaration on HIV/AIDS at ASEAN's seventh summit in Bandar Seri Begawan, where heads of government pledged joint leadership against the epidemic.

Although media coverage often concerned government action, only one article (in 2001) included statements by Heads of State or heads of government. Coverage from several countries (including China, Ghana, Jamaica and Kazakhstan) focused on efforts to change laws and policies to facilitate a more effective response to HIV/AIDS. On 17 October 2002, the ***South China Morning Post*** reported that China's first law to protect HIV-infected people from discrimination had been passed in Suzhou City (Jiangsu Province, eastern China).

Although a substantial share of media coverage could be interpreted as stigmatizing, a larger share of articles challenged HIV-related stigma and discrimination in 2002, especially in Brazil, China, Ghana, Jamaica, the Russia Federation and Zimbabwe. Media coverage also focused heavily on efforts to prevent the spread of HIV among young people.

Caution is merited when attempting to draw broad conclusions on a global or regional basis from experience in 10 countries. None the less, the following findings appear plausible:

- In key countries where the HIV epidemic is either rapidly emerging or growing more serious, there is evidence that advocacy is helping to increase public awareness and concern. In key countries where HIV/AIDS is worsening, the decline in coverage between 2001 and 2002 is a potential cause for concern.
- As reflected in media coverage, advocacy is having an important impact on the policy environment of many countries, as national decision-makers consider changes to laws and policies to strengthen the response to the epidemic.
- The limited visibility of national leaders in media coverage suggests that many senior leaders remain disengaged from the fight against HIV/AIDS.
- In certain countries, the stigma associated with HIV/AIDS may be declining somewhat as media coverage of the disease becomes more pronounced. Nevertheless, media coverage underscored that HIV-related stigma and discrimination remain serious threats to an effective response in many parts of the world.

II. National Commitment and Action Indicators

1. **Amount of national funds spent by governments on HIV/AIDS**
2. **National Composite Policy Index**

A. Strategic plan

1. Country has developed multisectoral strategies to combat HIV/AIDS
2. Country has integrated HIV/AIDS into its general development plan
3. Country has a functional national multisectoral HIV/AIDS management/ coordination body
4. Country has a functional national HIV/AIDS body that promotes interaction among government, the private sector and civil society
5. Country has a functional HIV/AIDS body that assists in the coordination of civil society organizations
6. Country has evaluated the impact of HIV/AIDS on its socioeconomic status for planning purposes
7. Country has a strategy that addresses HIV/AIDS issues among its national uniformed services (including armed forces and civil defence forces)

B. Prevention

1. Country has a general policy or strategy to promote information, education and communications (IEC) on HIV/AIDS
2. Country has a policy or strategy promoting reproductive and sexual health education for young people
3. Country has a policy or strategy that promotes IEC and other health interventions for groups with high or increasing rates of HIV infection
4. Country has a policy or strategy that promotes IEC and other health interventions for cross-border migrants
5. Country has a policy or strategy to expand access, including among vulnerable groups, to essential preventative commodities
6. Country has a policy or strategy to reduce mother-to-child transmission (MTCT)

C. Human rights

1. Country has laws and regulations that protect against discrimination people living with HIV/AIDS
2. Country has laws and regulations that protect against discrimination groups of people identified as being especially vulnerable to HIV/AIDS
3. Country has a policy to ensure equal access for men and women to prevention and care, with emphasis on vulnerable groups
4. Country has a policy to ensure that HIV/AIDS research protocols involving human subjects are reviewed and approved by an ethics committee

National Commitment and Action Indicators *(continued)*

2. National Composite Policy Index (continued)

D. Care and support

1. **Country has a policy or strategy to promote comprehensive HIV/AIDS care and support with emphasis on vulnerable groups**
2. **Country has a policy or strategy to ensure or improve access to HIV/AIDS-related medicines, with emphasis on vulnerable groups**
3. **Country has a policy or strategy to address the additional needs of orphans and other vulnerable children**

Country-level information

To measure national progress in implementing the Declaration of Commitment, UNAIDS applies three separate yardsticks:

- the degree of national commitment and action, as measured in terms of the amount of domestic resources devoted to HIV/AIDS-related activities and in national adoption of policies and practices set forth in the Declaration;
- the degree to which national commitment and action are reflected in the implementation of services that reach those who need them, increases in the level of HIV-related knowledge among key populations, and reductions in risky behaviour; and
- the degree to which national commitment and action result in concrete progress in reducing the number of new infections.

This section of the report, based on 103 national reports, looks at the first of these yardsticks – national commitment and action as measured in terms of resources and adoption of sound HIV-related policies.

- 90% of these reports were developed by National AIDS Commissions or equivalent bodies.
- In two-thirds of cases, input from civil society representatives was sought.
- In 53% of country reports, people living with HIV/AIDS were consulted. Involvement of people living with HIV/AIDS appears highest in North Africa and the Middle East (71% of respondent countries), followed by sub-Saharan Africa (71%), Eastern Europe and Central Asia (63%), South and South-East Asia (57%), and high-income countries (none).
- Three-quarters of countries state that national reports are publicly available.

1. Amount of national funds spent by governments on HIV/AIDS

While recognizing that resources are severely limited in many of the most heavily affected countries, the Declaration of Commitment calls on governments in low- and middle-income countries to increase the level of resources devoted to HIV/AIDS programmes.

UNAIDS estimates that total domestic government spending on HIV/AIDS programmes in 2002 by 58 low- and middle-income countries equaled approximately US$995 million – a doubling of the amount documented in 1999. In addition, UNAIDS estimates that HIV-affected households in these countries spent a roughly equal amount in 2002.

In estimated government expenditures on HIV/AIDS activities in 2002, UNAIDS focused on funds actually disbursed rather than on amounts authorized but not actually made available for programming.

Although there is evidence that many governments are increasing their outlays for HIV/AIDS-related activities, much of the increase over 1999 government expenditures is likely attributable to improved reporting on national efforts. Three-quarters of domestic HIV/AIDS spending in 2002 can be traced to seven middle-income countries: Brazil, Colombia, Mexico, the Russia Federation, South Africa, Thailand and Venezuela. Various analyses comparing spending on HIV/AIDS in low- and middle-income countries with overall government budgets indicate that many countries have yet to prioritize the response to HIV/AIDS in national resource allocations.

A region-by-region review reveals the following examples of domestic support for HIV/AIDS programmes:

- ***East Asia and the Pacific***. The Chinese Central Government increased its spending on HIV prevention from approximately US$1.8 million in 2001 to US$12 million in 2002.
- ***Eastern Europe and Central Asia***. In this region, where HIV is spreading most rapidly, governments devoted relatively small sums to HIV/AIDS-related activities: US$10 million in Belarus, US$2.7 million in Kazakhstan, US$219,000 in Kyrgyzstan, and US$132,000 in Tajikistan.
- ***Latin America and the Caribbean***. Latin America includes middle-income countries that have directed substantial domestic government resources towards the fight against HIV/AIDS, including Brazil (US$750 million in 2002), Mexico (US$212 million), and Venezuela (US$71 million). Argentina, which, in 2002, confronted a severe economic crisis, spent an estimated US$75 million on HIV/AIDS programmes. Governments in Central America and the Caribbean spent significantly less domestic resources on HIV/AIDS, but this is partially explained by the fact that most of these countries are relatively small. Antigua, a country of 68,000, spent US$259,000 on HIV/AIDS programmes in 2002.
- ***South and South-East Asia***. The Vietnamese Government spent US$4 million on HIV/AIDS in 2002, with 91% of such expenditures supporting HIV-prevention activities. With per capita gross national income of US$260, Cambodia spent nearly US$2 million on HIV/AIDS programmes in 2002. Myanmar, which is experiencing the steepest increase in HIV infection in the region, spent approximately US$3.4 million in domestic government funds on HIV/AIDS.

- ***Sub-Saharan Africa***. Some governments (such as Lesotho and Malawi) have committed to allocating 2% of their governmental budgets to HIV/AIDS programmes. In South Africa, national and provincial governments have budgeted approximately US$160 million for the 2003 fiscal year. Botswana, an upper-middle-income country of 2 million people, spent US$70 million on HIV/AIDS programmes in 2002. Nigeria, a low-income country of 127 million, where HIV infection is rapidly spreading, spent approximately US$14.1 million in domestic government resources on HIV/AIDS programmes.

2. Government HIV/AIDS policies

The Declaration of Commitment envisions the rapid development and implementation of sound national policy frameworks to guide action on HIV/AIDS. A favourable policy environment is required to encourage multisectoral action against the HIV epidemic and to ensure that national responses are as strategic as possible. Comprehensive policy frameworks also protect and promote human rights, recognize the epidemic's gender dimensions, contribute to the eradication of stigma and discrimination, and promote the active involvement of people living with HIV/AIDS.

To assess the degree to which countries have adopted and implemented the range of HIV/AIDS policies endorsed by the Declaration of Commitment, UNAIDS developed a National Composite Policy Index composed of 20 indicators that concern most, although not all, policy issues mentioned in the Declaration. Indicators address four key policy directions for effective national action:

- development, implementation and mainstreaming of strategic national AIDS plans;
- prevention of HIV transmission;
- protection and promotion of human rights; and
- care and support for people living with or affected by HIV/AIDS.

These indicators were reflected in a 20-question survey, which was sent to the 189 Member States that endorsed the Declaration of Commitment. In completing the questionnaire, countries had access to a guidance document prepared by UNAIDS in 2002, *Monitoring the Declaration of Commitment: Guidelines on Construction of Core Indicators*. Countries were asked to use a standard format generated by UNAIDS for reporting on the 20 indicators in the National Composite Policy Index, responding to each question by answering yes, no, or not applicable and, where appropriate, providing written comments or explanations.

As of 1 June 2003, 87 countries had submitted complete responses to the Policy Index questionnaire – 23 from sub-Saharan Africa, 8 from North Africa and the Middle East, 15 from Asia and the Pacific, 20 from Latin America and the Caribbean, 11 from Eastern Europe and Central Asia, and 10 from high-income countries. This section summarizes the answers provided by the 87 responding countries. Subsequent responses did not reveal significant variations in the main findings. Where questions were not relevant to particular national responses (because, for example, the country had low HIV prevalence) responses from these countries were not considered in the calculation of percentages cited in the report.

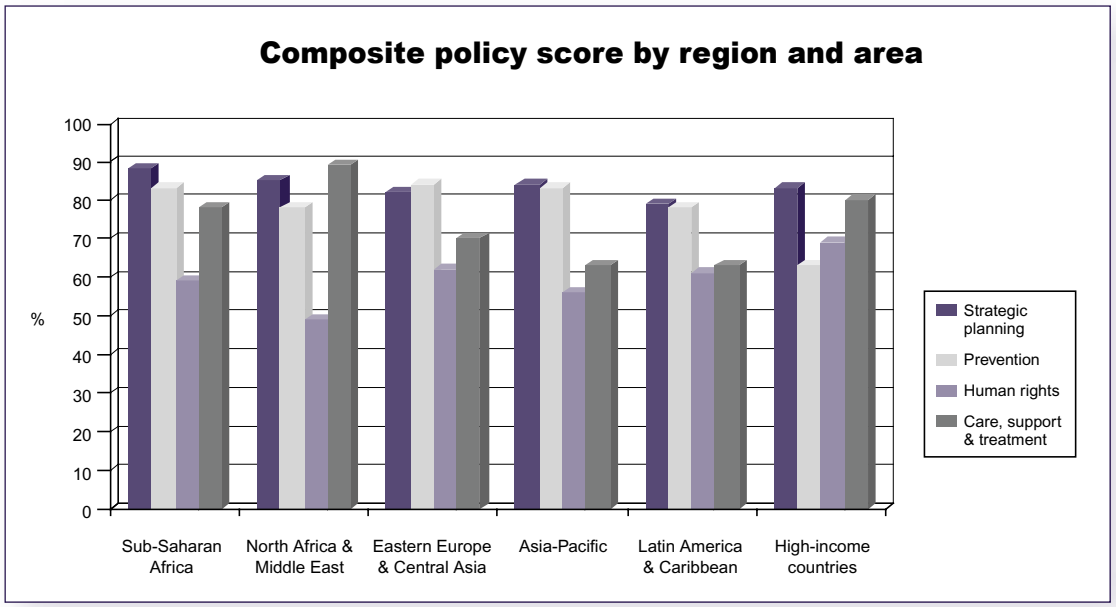
Significant differences are apparent, however, in the positive response rate for specific questions, indicating that national policy development is much stronger in some areas and

among some respondent countries than in others (see graph below). Among the different policy areas, for example, the strongest scores were found with respect to leadership, commitment and prevention. The lowest scores were found to be in the areas of human rights policies, especially laws and regulations in place for vulnerable groups and ensuring equal access to prevention and care services for men and women.

Although there are relatively few discernable regional variations between policy areas, the scores for high-income countries are often notably lower than for other regions. Several potential explanations exist. The response rate for high-income countries was comparatively low, and many of the questions in the UNAIDS survey were specifically geared towards obtaining information about the response to HIV/AIDS in developing countries, where 95% of the people with HIV/AIDS live.

Although the results suggest some progress in developing comprehensive HIV/AIDS policy frameworks, caution is recommended in interpreting findings. As numerous countries noted in their responses, and as subsequent sections of this report confirm, adoption of a recommended policy does not ensure that the policy is effectively translated into action.

In particular, countries report that the translation from policy to action is often inhibited by limited financial resources or technical capacity. Moreover, while a low score is evidence that additional work is needed in policy development and implementation, the absence of a formal policy in a particular area may not mean that no services in this area exist at country level. ***Bangladesh***, for example, reports that, while formal national policies do not exist in many prevention areas, numerous NGOs are undertaking substantial work in these areas (e.g., with vulnerable groups and young people.)



In addition to the National Composite Policy Index data, a joint UNAIDS/USAID project has sought to further document changes in national policy over the past two years. This study, called the AIDS Program Effort Index (API), discussed in further detail at the end of this section, is based on information provided by national experts in 44 countries regarding the existence of programme elements and quality. API findings indicate that:

- significant positive changes in policy have taken place over the past two years, with the greatest progress occurring in Africa and Asia;
- notable improvements were found to have been made in organization, political support and resource availability, while limited improvement was reported for human rights and regulatory environment; and
- a quarter of countries report having adopted multisectoral strategies and starting programmes for PMTCT and VCT over the last two years.

These findings are in keeping with those of the composite policy index and give additional credence to the conclusion that positive changes in the HIV/AIDS policy environment have occurred since adoption of the Declaration of Commitment.

The data gathered and presented here have led UNAIDS to conclude ***that significant progress has been made towards reaching many of the 2003 targets regarding policy development as outlined in the Declaration of Commitment.***

A. Strategic plan

A1 Country has developed multisectoral strategies to combat HIV/AIDS

The Declaration of Commitment requires that all countries develop and implement multisectoral national AIDS strategies by 2003. Among the 87 countries responding to the UNAIDS survey, 93% say they have adopted national strategies, including all countries surveyed in sub-Saharan Africa, Asia and the Pacific, and Eastern Europe and Central Asia. High-income countries are less likely to have adopted multisectoral national plans.

- ***Policy development for emerging epidemics***. Positive responses were mainly received from those countries that are heavily affected by the epidemic. Several countries with more recent epidemics or low prevalence rates are either in the process of developing national multisectoral plans or are concentrating their national responses in the health sector.
- ***Updating national strategies***. As circumstances change (such as the epidemic's transition from localized to generalized, the emergence of treatment programmes as a feasible option, and the development of affordable approaches for prevention of mother-to-child transmission), countries have recognized the need to revise and update their national strategies. ***Cambodia*** and ***South Africa***, for example, are in the process of revising their national plans. In August 2002, the Indonesian National AIDS Council developed a new multisectoral AIDS strategy (finalized in April 2003) through a consultative and participatory process with civil society, the provinces, the private sector and people living with HIV/AIDS.
- ***Challenges to a multisectoral response***. Several countries report that national responses remain concentrated in the health sector. While policies themselves

may be comprehensive, they often remain unimplemented due to lack of financial, technical or human resources.

A2 Country has integrated HIV/AIDS into its general development plan

In adopting the Declaration of Commitment, countries agreed by 2003 to integrate HIV/AIDS into the mainstream of development planning, including in poverty eradication strategies, national budget allocations, and sectoral development plans. This commitment recognizes both the centrality of HIV/AIDS to future development prospects (a point most recently underscored in the ***Human Development Report 2003***, produced by the United Nations Development Programme (UNDP)) and the importance of creating synergistic responses to the many problems that increase vulnerability to HIV/AIDS and exacerbate the epidemic's impact on societies, communities and households.

Ninety-two per cent of respondent countries with the above-mentioned development plans report having integrated HIV/AIDS into these instruments. Survey results were slightly lower in Asia and the Pacific and in Latin America and the Caribbean, with some respondents expressing a less pressing need for such integration, given their relatively low HIV prevalence rates.

A3 Country has functional national multisectoral HIV/AIDS management/ coordination body

A4 Country has a functional national HIV/AIDS body that promotes interaction among government, the private sector and civil society

A5 Country has a functional HIV/AIDS body that assists in the coordination of civil society organizations

Key priorities reflected in the Declaration of Commitment include the active involvement of diverse stakeholders in the national response and maximum coordination of HIV/AIDS activities. By 2003, the Declaration requires that countries will have fostered collaboration and the development of innovative partnerships between public and private sectors. The Declaration further commits countries to have, by 2003, established and strengthened mechanisms to involve the private sector, civil society partners, people living with HIV/AIDS, and vulnerable groups in the national response.

- ***High prevalence of policy coordination bodies.*** Eighty-eight per cent of countries responding to the UNAIDS survey report having created operational national multisectoral bodies to manage and coordinate national efforts. Eighty-nine per cent reportedly have a body to facilitate interaction between government, the private sector, and civil society. Fewer countries – 81% – have a body that helps coordinate civil society actions relating to HIV/AIDS.

  Frequently, the same body handles the multiple coordination roles mentioned in indicators A3, A4 and A5. In about one-quarter of countries reporting, these various roles are undertaken by the more recently established Country Coordination Mechanisms (CCM), which were set up specifically to support national efforts to obtain funding from GFATM. The ***United Republic of Tanzania***, by contrast, has multiple coordination bodies to address the various coordination challenges, including a national Commission on HIV/AIDS, the Tanzania Network of Civil Society Organizations, and the national CCM.

- ***Coordination at provincial and district levels***. Some countries have moved towards greater decentralization of HIV/AIDS planning and coordination. ***Papua New Guinea*** and ***Uganda***, for example, have provincial AIDS committees in addition to a national body. Similarly, in ***Morocco***, multisectoral committees have been established at regional and provincial levels in order to elaborate local strategic plans, coordinate activities, and monitor implementation. Other countries, such as ***Madagascar***, intend to establish AIDS coordination committees at these levels in the near future.

- ***Importance of adequate support for coordination efforts.*** Several countries, however, noted that these coordination bodies needed strengthening and greater financial and political investment in order to more effectively coordinate efforts. Although the Ministry of Health in the ***Russian Federation*** created an advisory council including key federal ministries, regional stakeholders and civil society organizations, the country reports that weak support from the highest political levels has impeded such efforts from being optimally effective.

A6 Country has evaluated the impact of HIV/AIDS on its socioeconomic status for planning purposes

Under the Declaration of Commitment, countries are, by 2003, to have evaluated the epidemic's socioeconomic impact, with a view towards development and implementation of strategies to mitigate the epidemic's burden on society.

Of the 28 countries with generalized HIV epidemics (> 1% prevalence in the adult population) that responded to the UNAIDS questionnaire, 16 (57%) reported they had studied the socioeconomic impact of HIV/AIDS in their country. ***The Philippines***, for example, with support from UNDP, has commissioned a multi-method, multi-disciplinary evaluation of the epidemic's impact to accelerate the mainstreaming of HIV/AIDS into the country's overall development planning. ***Malawi*** used technical assistance from UNDP and the World Bank to complete a series of sector-specific studies to better understand the epidemic's impact in different segments of society. An impact assessment in ***Belize*** was supported by the UN Theme Group on HIV/AIDS and coordinated by the Ministry of Economic Development. Some countries reported that various studies had been undertaken but that research findings had yet to be sufficiently synthesized to support national strategic planning.

A7 Country has a strategy that addresses HIV/AIDS issues among its national uniformed services (including armed forces and civil defence forces)

Focusing on the security implications of HIV/AIDS, the UN Security Council held its first debate ever on a health issue in January 2000 and subsequently endorsed a range of strategies to integrate HIV prevention into international peacekeeping operations, and highlighted the potential threat the epidemic poses for international security, especially in conflict and peacekeeping settings.

The UN General Assembly Special Session on HIV/AIDS further emphasized the security implications of HIV/AIDS by adopting the Declaration of Commitment, which called on countries to develop and implement, by 2003, national strategies to incorporate HIV/AIDS awareness, prevention, care and treatment elements into activities undertaken in response to emergency situations. By endorsing the Declaration of Commitment, countries committed themselves to providing training on HIV/AIDS awareness and to involving uniformed services in the development and implementation of HIV/AIDS awareness and prevention programmes.

A growing body of data underscores the critical importance of national efforts to address HIV/AIDS among uniformed services personnel. In many countries, where the military often serves as an important stabilizing force, HIV infection rates among uniformed personnel are significantly higher than for the population as a whole.

- ***Strategies for uniformed services.*** Seventy-eight per cent of countries responding to the UNAIDS questionnaire report that a national HIV/AIDS strategy is in place for uniformed services. This figure ranged between 81% and 90% for most regions but was found to be lower for Latin America and the Caribbean and for high-income countries, at 65% and 55% respectively.

There are indications that a growing number of countries are beginning to appreciate the threat the epidemic poses to national and regional security. More countries are using programmatic tools and other forms of assistance developed by UNAIDS.

Addressing HIV/AIDS among uniformed services in Botswana and the Laos People's Democratic Republic

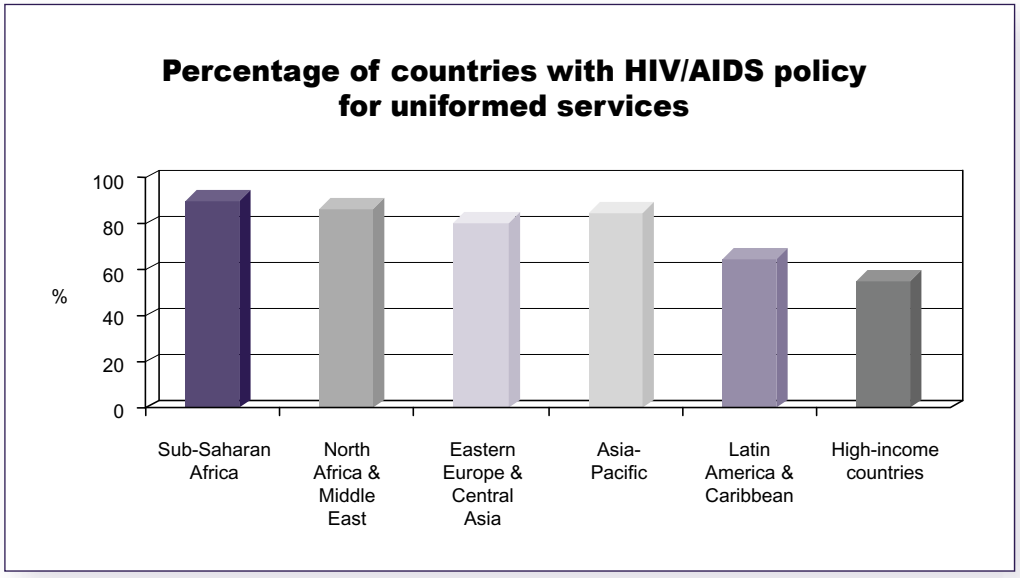
In Laos, the Ministries of Defence and Security are members of the new National Committee for the Control of AIDS. Both police and army were included in the behavioural component of the country's second-generation surveillance. Policy and army are preparing to train peer educators, and plans are in place to launch a Lao Military and Police Youth HIV/AIDS Response.

Full-time HIV/AIDS focal points were appointed in 2002 in Botswana's police department, defence force and prison security service. Activities undertaken in 2002 include prevention programmes, training of peer educators, situation analysis and outreach, and initiatives to discourage rape and sexual assaults.

- ***Weak coordination with emergency relief efforts***. In addition to the information provided by countries on this question, independent monitoring by the UNAIDS Secretariat provides more detailed information on the degree to which countries have implemented the range of security-related measures envisioned in the Declaration of Commitment. This survey of 54 countries in 2003 found that 16 countries (29%) report coordination between national emergency relief structures and national HIV/AIDS mechanisms. Although some countries, such as ***Eritrea*** and ***Uzbekistan***, indicate that such processes are currently being established, it appears that the level of coordination between HIV/AIDS and emergency relief efforts is weak or non-existent in most countries.

- ***Limited HIV/AIDS training for emergency relief workers***. Furthermore, only 12% of countries provide training on HIV/AIDS control in emergency situations. A notable exception is ***Thailand***, which includes an HIV/AIDS component as part of its training for military personnel on war and post-conflict situations. Nearly half (47%) of countries responding to UNAIDS report that humanitarian organizations include HIV/AIDS workplace policies and programmes, with an especially high (75%) positive response rate in Africa.

- ***Framework for a strategic action plan***. A UNAIDS meeting on HIV/AIDS and National Security was held in 2002 to develop a framework for a strategic action plan that specifically addresses uniformed services. As a direct follow-up to the action plan, UNAIDS has adopted a parallel approach to targeting uniformed services through regional and national partnerships, covering a total of 36 countries. The objectives are to (1) prevent HIV transmission among uniformed services, with emphasis on young recruits through peer education training, condom provision and distribution, and care and support services; and (2) involve uniformed services as advocates in the fight against HIV/AIDS by ensuring their participation in national strategic planning on HIV/AIDS.



B. Prevention

Prevention-related targets in the Declaration of Commitment are largely driven by the Declaration's overall goal of reducing HIV prevalence among young men and women (aged 15-24) in the most affected countries by 25% by 2005 and worldwide by 2010. By 2003, under the Declaration of Commitment, countries are to have established national targets to reduce HIV incidence in vulnerable groups experiencing high or increasing rates of HIV infection. A standard package of 17 essential prevention interventions is outlined in Annex 1. This section summarizes findings on countries' adoption of recommended prevention policies, with information on actual access to prevention services summarized in a subsequent section of the report.

B1 Country has a general policy or strategy to promote information, education and communication on HIV/AIDS

Information, education and communication (IEC) on HIV/AIDS are crucial components of a comprehensive package of prevention services required to reduce the number of new HIV infections. IEC includes, but is not limited to, activities such as mass media campaigns, school-based AIDS education, and peer education programmes, which aim to bring about changes in knowledge and behaviour that reduce the risk of HIV exposure and infection.

Eighty-eight per cent of responding countries indicate they have policies concerning IEC. Regionally, the percentages of countries with such policies in place are high, with all regions scoring 80% or higher. ***Botswana***, for example, has established a 25-member Behaviour Change and Communications Advisory Board to advise on programmatic issues. The ***Lao People's Democratic Republic*** seeks to ensure knowledge and awareness of HIV/AIDS among 85% of the population by 2005, and 100% awareness by 2010 – a major national undertaking in light of the country's 47 different ethnic groups that have multiple languages and varied cultural practices.

Responses suggest that countries need to appreciate a comprehensive strategy for information, education and communication as an essential element in HIV prevention. There is extreme urgency for countries with generalized and concentrated epidemics to have concrete coverage targets to guide programmatic responses. ***Burkina Faso***, for example, a country with an adult HIV prevalence rate of 6%, has no national strategy for the provision of information, education and communication on HIV/AIDS. ***Peru***, by contrast, has an IEC strategy that encourages monogamy and postponement of sexual debut but does not formally promote condom use among the general population. Other countries, such as ***Papua New Guinea***, report that they have no formal IEC strategy but are implementing IEC programmes.

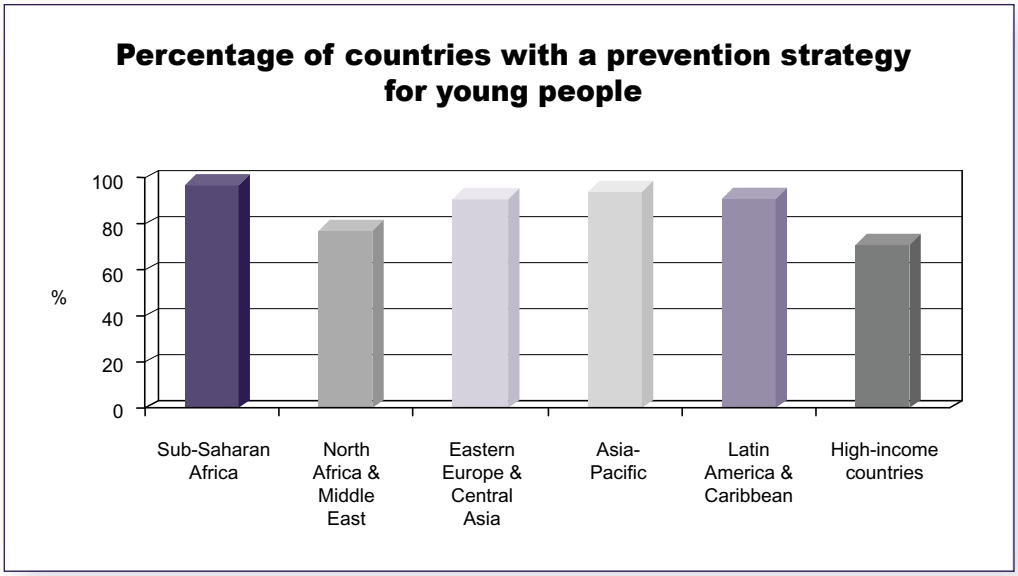
Promoting AIDS awareness and education in Armenia

Armenia's National Programme on HIV/AIDS Prevention prioritizes awareness-raising information campaigns for the general population, mass media activities, journalist training, creation of voluntary counselling and testing sites in major cities, and establishment of a national information centre and AIDS hotline.

B2 Country has a policy or strategy promoting reproductive and sexual health education for young people

By 2003, according to the Declaration of Commitment, countries are to have developed or strengthened strategies, policies and programmes to expand high-quality, youth-friendly information and sexual health education and counselling services. By this year, countries are also required to strengthen reproductive and sexual health programmes and to involve families and young people in planning, implementing and evaluating HIV/AIDS programmes.

Eighty-eight per cent of respondent countries report having in place a policy or strategy to promote reproductive and sexual health education for young people, although high-income countries and countries in North Africa and the Middle East are less likely to have adopted such policies than other regions. In the high-income grouping, which includes Western Europe, several countries such as ***Macedonia***, ***Malta, Serbia and Montenegro*** have not yet developed such policies.



It is worth noting that most countries from the Asia-Pacific, Latin America-Caribbean and sub-Saharan African regions, with their huge populations of young people, have reported putting in place policies that should provide the supportive environment for large-scale programming coverage. There are some exceptional examples of demonstrable commitment among a few countries whose national policies on adolescent sexual and reproductive health are integrated into national or sectoral development planning processes, other than the health sector.

- ***Uganda*** reports that its National Adolescent Health Policy is an integral component of its national development process.
- In ***Honduras***, the Ministry of Health has adopted specific targets on sexual and reproductive health for youth.
- ***Cambodia*** is undertaking a range of efforts to integrate HIV/AIDS into the activities of the Ministry of Education, Youth and Sports.
- Dedicating 2002 to a multi-faceted campaign to combat the spread of HIV, the Prime Minister of ***Nepal*** embarked on a national effort that specifically prioritizes prevention efforts among young people.
- Another country without a formal policy, ***Ethiopia***, says efforts are under way to develop one, citing a national youth forum that developed a three-year HIV/AIDS plan.
- In an effort to boost national actions, the ***ASEAN*** Cooperation Forum on HIV/AIDS is intensifying regional advocacy efforts for education and life-skills-based training for young people on sexual and reproductive health.

Prioritizing HIV prevention among young people in Namibia

Namibia's 2nd National Development Plan seeks, by 2004, to educate 80% of students in educational institutions about reproductive health, sexuality, HIV/AIDS and STIs. In collaboration with UNICEF and the University of Maryland School of Medicine, the Ministry of Basic Education administers the 'My Future is My Choice' programme that provides young people with facts about sexual health and reproduction, pregnancy, STIs and HIV/AIDS, and that teaches skills in making healthy life choices.

B3 Country has a policy or strategy that promotes IEC and other health-related interventions for groups with high or increasing rates of HIV infection

Eighty-one per cent of countries report having policies or strategies to prevent HIV among vulnerable populations. Especially encouraging is the high rate of positive responses in Eastern Europe and Central Asia (90%), where such policies are especially important, given the concentration of the epidemic among such vulnerable groups. For most other regions, this figure was above 85%, except in Latin America and high-income countries, where it was 75% and 60%, respectively.

Many countries have reported prioritized interventions in diverse populations, depending on national circumstances. For example:

- ***Brazil*** reports that its IEC strategies place particular emphasis on men who have sex with men, sex workers, young people, and injecting drug users.
- With assistance from international donors, ***Nepal*** is implementing various prevention strategies targeting sex workers, their clients, and injecting drug users.
- ***Moldova***'s five-year strategy on HIV/AIDS and STIs prioritizes harm reduction for injecting drug users, including initiation of the region's first methadone maintenance programme.
- ***Zimbabwe***'s national strategy promotes interventions for sex workers, youth, mobile populations and prison inmates, among other populations.

B4 Country has policy or strategy that promotes IEC and other health-related interventions for cross-border migrants

The Declaration of Commitment requires that, by 2005, countries will have developed and begun implementation of HIV-prevention strategies for migrants and mobile workers, including the provision of information on health and social services. This target in the Declaration addresses the well-documented correlation between population mobility and heightened HIV risk.

Two years from the target date for realization of this goal in the Declaration, only 47% of countries report having an HIV prevention policy for cross-border migrants. Some countries, such as Indonesia, are reportedly in the process of developing such national strategies.

Despite the rather low proportion of countries that address cross-border migrants in national policy, a number of countries have undertaken potentially important initiatives in this area.

- ***Zimbabwe*** has pursued various strategies to address the risks faced by cross-border migration, including the USAID-sponsored 'Corridors of Hope' project for long-distance drivers.
- ***Guatemala*** reports that several cross-border initiatives are operating in Central America, and Namibia indicates that the National Commissioner for Refugees has implemented HIV/AIDS programmes at all refugee collection points and in the country's main refugee camp, where approximately 22,000 people live.
- In the Asian region, ***ASEAN*** has highlighted population mobility as a priority area in its programme on HIV/AIDS. Consensus has been reached for expanded prevention strategies, including pre-departure, post-arrival, and returnee reintegration programmes for the millions of workers who are employed outside their countries.

B5 Country has a policy or strategy to expand access, including among vulnerable groups, to essential preventative commodities

The Declaration of Commitment requires that, by 2005, countries have expanded access to essential prevention commodities, including male and female condoms and sterile injecting equipment. This requirement in the Declaration acknowledges the current shortfalls in the supply and accessibility of key prevention tools and commits the international community to taking aggressive action to close current gaps.

- ***Condom access gap***. The United Nations Population Fund (UNFPA) estimates that the current supply of male condoms (6 to 9 billion a year) represents only one-quarter of what is needed. The present supply of male condoms in Africa, where the epidemic is overwhelmingly driven by sexual transmission, amounts to only approximately three condoms per year for each adult male. UNFPA estimates that international spending on condoms in 2000 represents only 19% of what was needed. Likewise, even though numerous studies have demonstrated that female condoms are both effective in preventing HIV transmission and generally acceptable to women and their sexual partners, access to female condoms remains limited in low- and middle-income countries.
- ***Unsafe injection practices***. In low- and middle-income countries, most health-care settings do not adhere to universal precautions, including measures to ensure that injections are sterile. WHO experts estimate that unsafe injections were the source of 160,000 infections in the Asia-Pacific region in 2000.
- ***National policy development***. Eighty-one per cent of countries responding to the questionnaire report having a national policy to expand access to essential preventative commodities. While the global score is relatively high, the comparatively low score for sub-Saharan Africa (73%) underscores the need for countries to take immediate action to ensure achievement of the Declaration's 2005 target.

Responses reveal that countries are pursuing a wide range of strategies to increase the accessibility of prevention technologies.

- ***Kazakhstan*** reports that the number of syringes distributed to IDUs in 2002 (16,000) represents a two-and-a-half-fold increase over 2001; at the same time, distribution of

condoms doubled in 2002, and the country opened 69 new voluntary counselling and testing sites.

- In 2002, ***Botswana*** procured 31 million condoms through the public sector, leading to the distribution of 44 condoms per sexually active person (aged 15-59), and the country also established quality-assurance mechanisms for its condom distribution programmes.
- In the ***Lao People's Democratic Republic***, national policy seeks to achieve access to VCT in all provinces by 2005.

Expanding condom access in India

The Indian Government has adopted a national strategy to expand access to condoms through free distribution and social marketing schemes. The national strategy includes targeted interventions to enhance condom access among especially vulnerable groups, such as sex workers, men who have sex with men, injecting drug users, transport workers, and migrant workers.

B6 Country has a policy or strategy to reduce mother-to-child-transmission of HIV/AIDS

The Declaration of Commitment envisions a 20% reduction by 2005, and a 50% reduction by 2010, in the number of HIV-infected newborns born to HIV-infected mothers. Achievement of this goal requires that countries adopt and implement strategies to bring to scale a comprehensive set of services to reduce the risk of mother-to-child transmission.

Eighty-eight per cent of countries report having in place national PMTCT policies. The highest scores were found in Latin America and the Caribbean (100%) and in sub-Saharan Africa (91%). Of some concern, however, is the relatively low positive response (78%) in Asia, where PMTCT has already emerged as a critical public health imperative in several countries.

Information on implementation of the Declaration of Commitment reveals a broad range of national responses.

- In 2002, ***Belarus*** embarked on a campaign to train obstetricians, gynaecologists and paediatricians in effective methods for PMTCT.
- ***Malawi*** launched a PMTCT initiative in 2003 that includes national guidelines, infant-feeding strategies for HIV-positive women, and negotiation of a free supply of nevirapine and the appropriate diagnostic tools.
- ***Botswana*** is ramping up its planned national programme for universal access to free AZT and nevirapine for all pregnant women, as well as free infant formula for mothers who choose to formula feed. Between December 1999 and June 2002, the percentage of pregnant women receiving counselling in PMTCT increased from 60% to 74%, while the share of HIV-positive pregnant women who received AZT grew from 30% to 60%.

C. Human rights

C1 Country has laws and regulations that protect against discrimination people living with HIV/AIDS

According to the Declaration of Commitment, "Respect for the rights of people living with HIV/AIDS drives an effective response". The Declaration requires that, by 2003, countries will have enacted, strengthened or enforced legislation to eliminate all forms of discrimination against people living with HIV/AIDS and to combat HIV-related stigma and social exclusion.

Results of the policy survey indicate that many countries risk falling short of the Declaration's vision of grounding national responses in respect for human rights. Worldwide, 62% of countries say they have legal measures in place to protect people living with HIV/AIDS from discrimination. In sub-Saharan Africa, where approximately 30 million people are currently living with HIV/AIDS, barely half (52%) of respondent countries have adopted anti-discrimination mandates. Similarly, in North Africa and the Middle East, only one in two countries have such laws.

Moreover, national responses indicate that these figures may actually overstate official commitment to eradication of HIV-related stigma and discrimination. Several countries that responded positively have not adopted HIV-specific anti-discrimination measures but rely instead on general laws that prohibit a broad range of discriminatory practices. Others say that, while national laws technically prohibit HIV-based discrimination, public awareness of such laws is often low, with inadequate means to enforce the measures.

Fighting HIV discrimination in the Netherlands

Article 1 of the constitution of the Netherlands prohibits discrimination on any grounds. In addition, the country's Medical Examination Act provides that no person may be denied unemployment compensation or insurance on medical grounds. Law in the Netherlands bars employers from requiring prospective employees to submit to an HIV test, and the country has no travel restrictions on people living with HIV.

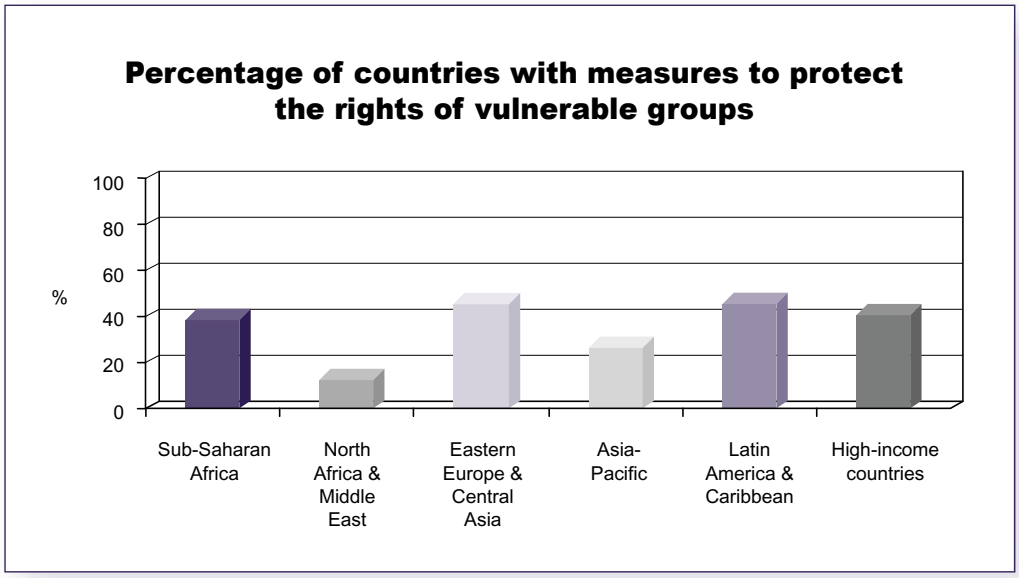
C2 Country has laws and regulations that protect against discrimination of groups of people identified as being especially vulnerable to HIV/AIDS

The stigma and discrimination that impede an effective response to the epidemic extend not just to people who are infected with HIV but to members of groups that are especially vulnerable to infection, including injecting drug users, men who have sex with men, sex workers, and vulnerable young people. The Declaration recommends that, by 2003, countries should strengthen or enforce, as needed, legal measures to eliminate discrimination against, and promote the human rights of, members of vulnerable groups. Such legislative initiatives play an essential role in a comprehensive response to HIV/AIDS, including helping to ensure access to HIV prevention, care and treatment services.

- ***Low prevalence of anti-discrimination laws for vulnerable populations***. National responses to this particular indicator were among the lowest for any indicator, with only 36% indicating that such anti-discrimination policies are in place for vulnerable populations. Positive responses were especially low in Asia and the Pacific and in North Africa and the Middle East.

- ***Officially-sanctioned discrimination***. In many parts of the world, vulnerable populations remain the targets of officially sanctioned discrimination. In many countries, homosexual conduct remains illegal and punishable by imprisonment, as is sex work. In some countries where injecting drug use is driving the epidemic, official policies towards this population are largely punitive, with little or no governmental emphasis on comprehensive prevention and care services for IDUs, such as drug awareness, HIV/AIDS education, and promotion of safer sexual practices.

- ***Deterrent to service access***. Measures to increase sex workers' access to prevention, care and support services, such as STI treatment and condom supplies, are constrained by legislative frameworks that penalize sex workers and deter them from seeking health care. By contrast, in countries such as ***Benin***, ***Côte d'Ivoire*** and ***Senegal***, where prevention efforts have specifically focused on sex workers and other vulnerable groups, such initiatives have effectively controlled HIV and STI incidence.



Even though most countries appear to be in danger of falling short of the Declaration's requirements in this area, some countries are displaying important leadership in protecting and promoting the rights of vulnerable populations. Several regions in ***Brazil***, for example, have reportedly adopted legislation outlawing discrimination on the basis of sexual orientation. Despite constraints related to legislative frameworks, a few countries (***Benin***, ***Brazil***, ***Cambodia***) have moved forward in improving equitable access of vulnerable populations to HIV-prevention services. ***Moldova*** has reportedly launched a comprehensive review of national legislation to ensure compliance with human rights conventions.

C3 Country has a policy to ensure equal access for men and women to prevention and care, with emphasis on vulnerable populations

The epidemic's burden on women and girls has grown considerably in recent years, with women now accounting for half of all people living with HIV/AIDS and nearly 60% of all HIV-infected people in sub-Saharan Africa. These trends reflect the multiple economic, legal and social inequities that confront women and girls in many parts of the world.

Cognizant of the need to integrate gender dimensions in national responses to the epidemic, the 189 Member States that endorsed the Declaration of Commitment agreed on several targets to empower women and girls to protect themselves from HIV infection. By 2005, countries are to implement national strategies promoting the rights of women and empowering women to make decisions on matters relating to their sexuality. By 2005, countries are to have measures in place to ensure the access of women and girls to comprehensive health care and services, including for sexual and reproductive health.

Policy Indicator C3 assesses the degree to which countries have taken action to ensure equity in access to HIV prevention, care and related services. Overall, 69% of countries say they have policies in place to ensure that women have equal access to HIV-related services. In roughly one in three countries, immediate action is needed to ensure gender equity in access to HIV/AIDS prevention and care services, as required by the Declaration.

Despite the failure of many countries to integrate gender equity into national HIV/AIDS frameworks, several countries are actively addressing service disparities between men and women. ***Kenya***'s Gender and HIV/AIDS Task Force, for example, has issued recommendations to ensure women's equal access to health care. In 2001, ***Cambodia***'s Ministry of Women's Affairs developed a national policy to promote the rights of women and girls at risk of HIV.

C4 Country has a policy to ensure that HIV/AIDS research protocols involving human subjects are reviewed and approved by an ethics committee

As a component of a stronger and more effective global research effort on HIV/AIDS, countries agreed under the Declaration of Commitment to ensure by 2003 that all HIV-related biomedical research trials are based on international guidelines and best practices and evaluated by independent ethical review committees. At present, 70% of countries surveyed say they currently mandate ethical review of HIV-related research protocols. Response rates are especially low in Eastern Europe and Central Asia, where less than one-half of countries ensure that clinical trial protocols are reviewed by en ethics committee.

India has developed guidelines to ensure that HIV/AIDS research involving human subjects are reviewed and approved by institution-based as well as national ethics committees. In the ***Philippines***, ethical guidelines have been developed by the National AIDS Council, providing direction on informed consent, confidentiality, care, discrimination and other issues pertinent to participation in clinical research.

D. Care and support

D1 Country has a policy or strategy to promote comprehensive HIV/AIDS care and support, with emphasis on vulnerable groups

The Declaration of Commitment affirms that "care, support and treatment are fundamental elements of an effective response". The Declaration's approach to care, support and treatment is comprehensive, encompassing not only ART but also other drugs for opportunistic infections and psychosocial care for HIV-infected and –affected individuals and families. Under the terms of the Declaration, countries are strongly encouraged to develop national strategies to provide comprehensive care services for HIV-affected individuals, families and communities by 2003.

More than three-quarters (76%) of countries surveyed by UNAIDS report having such policies in place. Scores are lower for Eastern Europe and Central Asia, reflecting the more recent emergence of the epidemic in the region. Given the rapid growth of HIV infection in Eastern Europe and Central Asia and the fact that more than 1 million people in the region are already living with HIV/AIDS, countries currently without comprehensive care strategies (i.e., more than one-third) will need to develop and implement such policies swiftly.

Recently, in response to declining prices for ART and to the increased availability of external support for HIV treatment programmes, many countries have taken action to increase access to comprehensive care. ***Viet Nam*** has expanded its network of HIV/AIDS counselling, care and management centres to 40 provinces. ***Malawi*** is using funding from the GFATM to increase access to care and treatment, to promote rational use of AIDS-related drugs including antiretrovirals, and to integrate HIV and TB care.

Several countries report that, while national strategies promote comprehensive HIV/AIDS care, implementation of such strategies has frequently faltered, often as a result of insufficient resources. ***Lesotho***, for example, has collaborated with NGOs in developing manuals for home-based care, clinical management of HIV/AIDS, counselling, nutritional care, and spiritual care and support for HIV-infected and -affected individuals. Yet, currently, ART is only available as post-exposure prophylaxis in health settings, and drugs to treat or prevent HIV-related opportunistic infections are not universally accessible. This year, ***China*** established more than 50 demonstration sites for HIV prevention and care, but national authorities acknowledge that the scale and coverage of the programme are currently insufficient in light of the country's sheer size and unparalleled population.

Promoting comprehensive HIV/AIDS care in Uganda

Uganda's national HIV/AIDS strategy for 2001-2006 seeks to reduce HIV-related morbidity, disability and mortality and to improve the quality of life for people living with HIV/AIDS. The multi-stakeholder framework relies on three major strategies:

- counselling, including voluntary counselling and testing;
- prevention of mother-to-child transmission; and
- clinical management of HIV/AIDS, including chemoprophylaxis, treatment of opportunistic infections, antiretroviral therapy, palliative care, and paediatric HIV/AIDS care.

D2 Country has a policy or strategy to ensure or improve access to HIV/AIDS-related medicines, with emphasis on vulnerable groups

By 2003, countries are required by the Declaration of Commitment to have in place comprehensive strategies to provide HIV-related drugs, including ART and drugs for the treatment and prevention of opportunistic infections. The Declaration calls for urgent efforts to provide the highest attainable standard of treatment for HIV/AIDS.

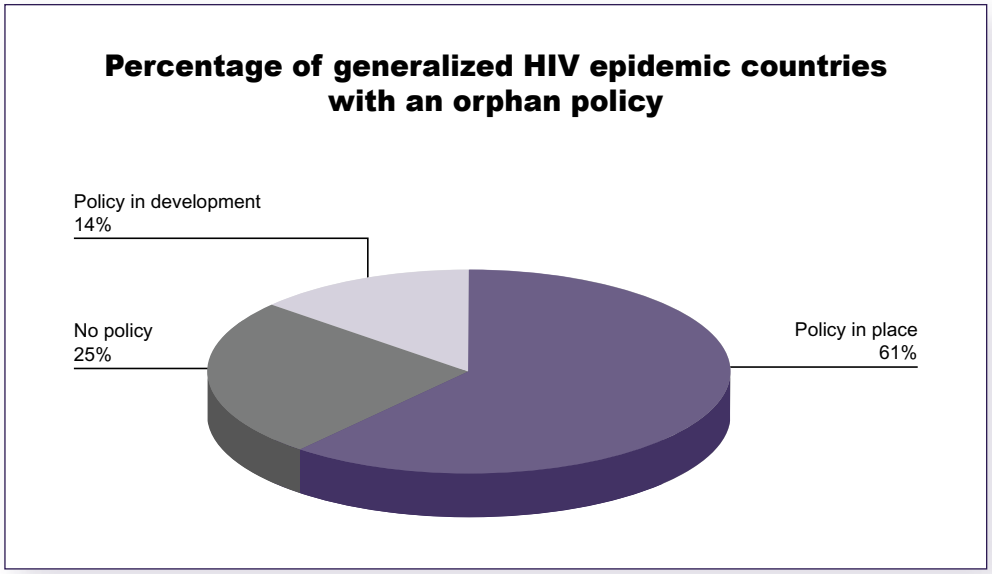
Eighty per cent of responding countries report having policies to ensure or improve access to HIV-related drugs. However, even though the Asia-Pacific region is home to 7.2 million people living with HIV/AIDS, less than two-thirds of countries in the region report having policies to promote access to HIV-related drugs.

Several countries, such as ***Armenia***, ***Belarus***, ***Burkina Faso*** and ***Malawi***, indicate that plans to expand access to HIV-related medications will benefit from new funding from the GFATM. ***Uganda*** cites its participation in the UNAIDS Accelerating Access Initiative as helping to achieve significant price reductions for HIV/AIDS medicines, and efforts to expand treatment access in Uganda have also been accelerated as a result of the importation of generic antiretroviral drugs. ***China*** reports that four ARV drugs have been domestically produced, yielding three different ARV 'cocktails'.

Yet responses to the survey also reveal continuing barriers to HIV/AIDS treatment access. Although ***Paraguay***'s National AIDS Programme provides ARV therapy to 300 people living with HIV/AIDS, the programme is typically halted each year for several months as a result of funding shortfalls. In ***India***, where the private sector produces generic ARV drugs, the public sector does not provide free ART, although free access to drugs for opportunistic infections is provided and various private companies provide ART coverage for their workers.

D3 Country has a policy or strategy to address the additional needs of orphans and other vulnerable children

HIV/AIDS has already orphaned an estimated 14 million children, and UNAIDS projects that the number of children orphaned by AIDS could increase to 25 million by 2010. Under the Declaration of Commitment, countries are, by 2003, to develop, and, by 2005, to implement, national policies and strategies to provide a supportive environment for orphans and other children made vulnerable by HIV/AIDS. Support services for orphans and other vulnerable children include appropriate counselling and psychosocial support, programmes to ensure enrolment in schools and access to shelter, access to nutritional, health and social services, and protection from violence, exploitation, discrimination, and other forms of abuse.



- ***Increasing impact of children orphaned by AIDS.*** Responses to the survey reveal that the growing burdens of caring for escalating numbers of children orphaned by AIDS are beginning to be felt in many countries. Although more countries are now grappling with official policies on orphans and other vulnerable children, integration of orphan support in national policy frameworks is uneven and insufficient.
- ***National policy frameworks.*** Of the 28 countries surveyed that have an HIV prevalence rate higher than 1%, 17 (61%) have policies to address the special needs and vulnerabilities of orphans and other vulnerable children, and another four (14%) are in the process of developing such policies. One in four still has no policy to provide a supportive environment to children orphaned or made vulnerable by AIDS.
- ***Examples of national responses***. According to national responses to the UNAIDS questionnaire, the growing impact caused by the increasing numbers of children orphaned by AIDS is generating diverse national responses.
  - — ***Namibia*** reports it has developed a national policy framework on orphans, convened a permanent task force on orphans and vulnerable children, and initiated a fund to increase resources for children-focused support programmes.
  - — ***Uganda*** and ***the United Republic of Tanzania*** report that national policies on orphans and other vulnerable children are in development.
  - — According to ***Cambodia***, a national fund exists to support services for children infected and affected by HIV/AIDS but resources are currently insufficient to meet existing needs.

Promoting comprehensive services for children orphaned by AIDS in Malawi

Malawi's national strategy on children orphaned by AIDS seeks through various capacity-building measures to enable communities and households to use available social capital and other resources to care for children affected by the epidemic. Ninety-seven community-based orphan-care groups exist in Malawi, with one in five offering educational support to enrolled children. The Ministry of Gender, Youth and Community Services administers an orphan registration system at national, district and community levels. Malawi's strategy emphasizes programmes to teach life skills and provide needed psychosocial support. Country officials cite the need for substantially greater resources to support these and other initiatives for orphans and vulnerable children, as well as the need in the future to address a broader array of issues, including protection of children from abuse, stigma and discrimination.

E. AIDS Program Effort Index

Complementing the findings of the National Composite Policy Index, the AIDS Program Effort Index (API) is intended to measure the amount of effort made by national programmes to confront the AIDS epidemic.

The survey asked experts in each country to quantify national efforts in 10 different programme categories. Forty countries were surveyed in 2000, and 54 in 2003. This rapid survey is not intended to rank countries, since the need for programme effort will vary according to the severity of the epidemic and since experts in different countries may use different standards in their judgements of quality. Nevertheless, the API is useful for highlighting areas of strength and weakness in national responses and for identifying progress over the past two-to-three years. This section presents results from 44 of the 54 countries surveyed in 2003.

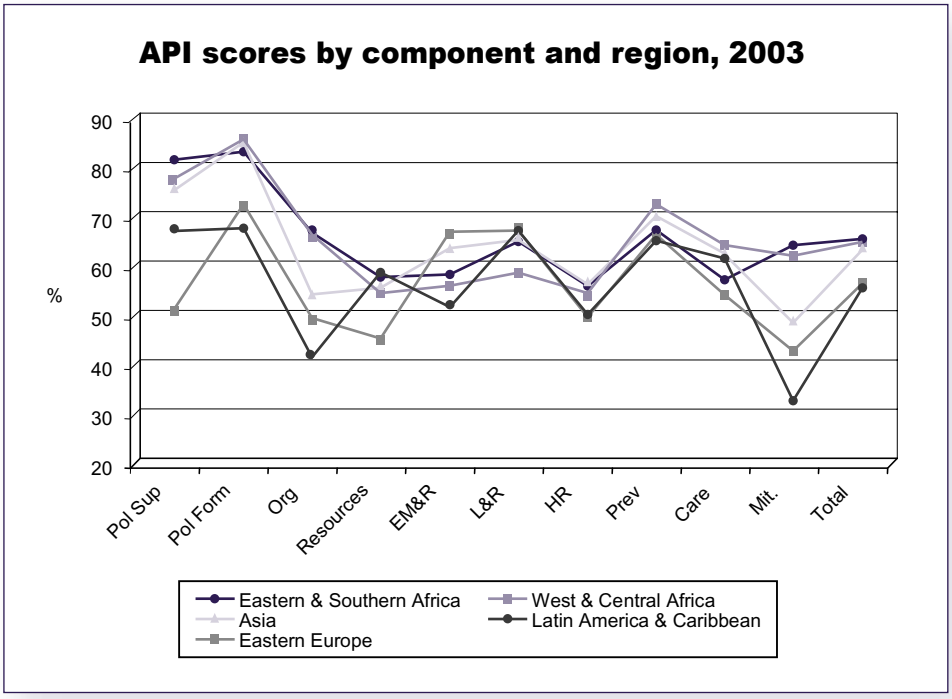
2003 AIDS Program Effort Index results. The figure opposite shows the profile of effort by category and region. Africa and Asia do relatively well on political support and policy formulation, and all regions show evidence of improvement with respect to HIV prevention. African countries are more likely to prioritize efforts to mitigate the epidemic's impact than are countries in other regions, where the epidemic is less severe. The weakest areas of national efforts are resources, human rights and care.

Several essential programme elements were reported to be implemented in almost all countries. These include comprehensive national policies; blood screening; STI treatment; legal basis for prevention measures such as IEC, condoms, STI treatment, and VCT; surveillance among pregnant women; and joining international key human rights conventions, such as the Universal Declaration of Human Rights, the Convention on the Rights of the Child, the International Covenant on Civil and Political Rights, the International Convention on the Elimination of Racial Discrimination and the Convention on the Elimination of All Forms of Discrimination against Women.

In spite of the nearly universal acceptance of the key international agreements on human rights, however, few countries have implemented effective measures to enforce these declarations,

such as setting up legal AIDS networks or focal points within governments for monitoring and ensuring compliance.

Most experts also give their countries low ratings on the level of resources allocated for prevention and care programmes. Other items that receive low scores include support for programmes for men who have sex with men or for injecting drug users, and widespread availability of ART and treatment for opportunistic infections.



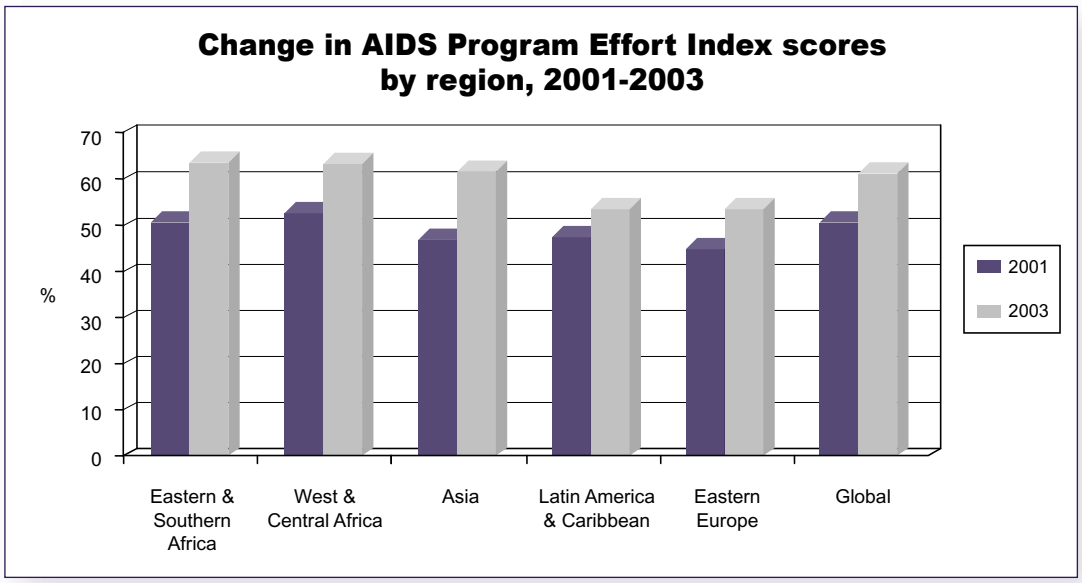
Key: Pol Sup = political support; Pol Form = policy formulation; Org = organizational structure; EM&R = evaluation, monitoring and research; L&R = legal and regulatory environment; HR = human rights; Prev = prevention; Care = care and treatment; Mit. = mitigation.

Improvements between 2001 and 2003. The API scores for 2003 can be compared with the scores for 2000 and with retrospective assessments for 2001 that were provided by experts in 2003. Analysis of this information indicates that important progress has been made in strengthening national HIV/AIDS policy development and implementation since 2000. Progress has been achieved in all regions, with the greatest improvements occurring in Africa and Asia (see figure overleaf). These improvements have been in organization, political support and resource availability, with the smallest improvements occurring in human rights and the legal and regulatory environment.

Specific improvements include:

- ***Resources***. Almost all countries reported improvements in the availability of resources. Funding increases occurred most often for prevention of mother-to-child transmission, antiretroviral therapy, human rights activities, voluntary counselling and testing, youth programmes, condoms, policy development and behavioural change communications.

- ***Multisectoral participation***. Ten of the 41 countries reported adopting multisectoral programmes since 2001. The government sectors most often involved in these new programmes included youth, transportation, finance, agriculture, labour, public works, tourism, trade and culture.
- ***Prevention***. One-quarter of the countries reported that programmes for prevention of mother-to-child transmission and voluntary counselling and testing have been under way since 2001.
- ***Political support***. Ten countries reported that civil society had become represented in the national AIDS coordinating body.
- ***Human rights***. Ten countries reported that they have recently implemented specific programmes to reduce stigma.



III. National Programme and Behaviour Indicators

1. **Percentage of schools with teachers who have been trained in life-skills-based HIV/AIDS education and who taught it during the last academic year**
2. **Percentage of large enterprises/companies that have HIV/AIDS workplace policies and programmes**
3. **Percentage of patients with sexually transmitted infections at health-care facilities who are appropriately diagnosed, treated and counselled**
4. **Percentage of HIV-infected pregnant women receiving a complete course of antiretroviral prophylaxis to reduce the risk of MTCT**
5. **Percentage of people with advanced HIV infection receiving antiretroviral therapy**
6. **Percentage of injecting drug users who have adopted behaviours that reduce transmission of HIV**
7. **Percentage of young people aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission (Target: 90% by 2005; 95% by 2010)**
8. **Percentage of young people aged 15-24 reporting the use of a condom during sexual intercourse with a non-regular sexual partner**
9. **Ratio of current school attendance among orphans to that among non-orphans aged 10-14**

To achieve sustainable progress against the epidemic, the policies endorsed by the Declaration of Commitment, as reflected in the indicators in Section II on national commitment and action, must manifest themselves in science-based programmes that reach those in need. Indicators in this section seek to measure the coverage of key HIV/AIDS interventions and the degree to which these interventions are promoting behavioural change and/or service utilization.

As explained in greater detail in the following discussion on each indicator in this section, UNAIDS used a variety of techniques and information sources to assess the breadth of current programmes. These include analysis of authoritative surveys that have recently been undertaken, the commissioning of additional surveys to address specific indicators, and collection of programme coverage data from relevant key informants.

1. Life-skills-based HIV/AIDS education in schools

Percentage of schools with teachers who have been trained in life-skills-based HIV/AIDS education and who taught it during the last academic year

The Declaration of Commitment requires that, by 2005, 90% of young people (aged 15-24) have access to critical prevention interventions, including services to develop the life skills needed to reduce vulnerability to HIV infection. By 2010, this target rises to 95%.

A critical element in reaching this target is the integration into school-based settings of life-skills-education programmes. Skills-based health education and interactive teaching methods have been shown to promote healthy lifestyles and reduce risky behaviours. Comprehensive life-skills programmes help young people refrain from unwanted or unhealthy behaviour and improve individual assertiveness, coping and communication skills. One example of such a comprehensive approach to life-skills education is the UN-sponsored FRESH (Focusing Resources on Effective School Health) Partnership (mainly involving the United Nations Children's Fund (UNICEF), the United Nations Educational, Scientific and Cultural Organization (UNESCO), WHO, and the World Bank), which focuses on skills-based education for HIV/AIDS prevention, school health policies on HIV/AIDS discrimination, a healthy school environment, and school-based counselling and health clubs for HIV/AIDS.

To obtain information for this report, countries were asked to report on life-skills activities in both primary and secondary schools. Countries were afforded the option of obtaining this information through a school-based survey or through aggregated programme monitoring data. Due to the weakness of current monitoring systems at country level, only 34 countries provided information on life-skills-based education programmes – 12 from sub-Saharan Africa, 7 from Asia and the Pacific, 8 from Latin America and the Caribbean, 2 from North Africa and the Middle East, and 5 from Eastern Europe and Central Asia. No high-income countries responded.

Information on life-skills-based education programmes in the 34 respondent countries is set forth in Annex 3. Although country-to-country comparison of available information is problematic (some report only on urban schools, others only on primary or secondary schools, and some only on portions of the composite indicator), available data suggest that many countries are making efforts to incorporate a life-skills approach into their educational programmes. Because of the absence of relevant information, it is not possible to extrapolate the experience of the 34 reporting countries to those that did not respond, nor is it wise to assume that failure to provide information means that non-respondent countries are not making progress in incorporating life-skills-based education.

- ***Sub-Saharan Africa***. Among the 12 respondent countries from sub-Saharan Africa, ***Botswana*** (see box) appears to be in the vanguard of regional efforts to promote life-skills-based education. ***Uganda*** has piloted an interactive school health education programme that integrates HIV prevention. A survey of more than 280 students (with an average age of 14), who had completed two years of the pilot programme, found that the proportion of students who reported being sexually active fell from 42.9% to 11.1% in the intervention group, while no significant change was recorded in the control group. Changes remained significant after taking into account gender or location (rural/urban). Students in the intervention group tended to speak more often to peers and teachers about sexual matters.

Promoting HIV prevention through education in Botswana

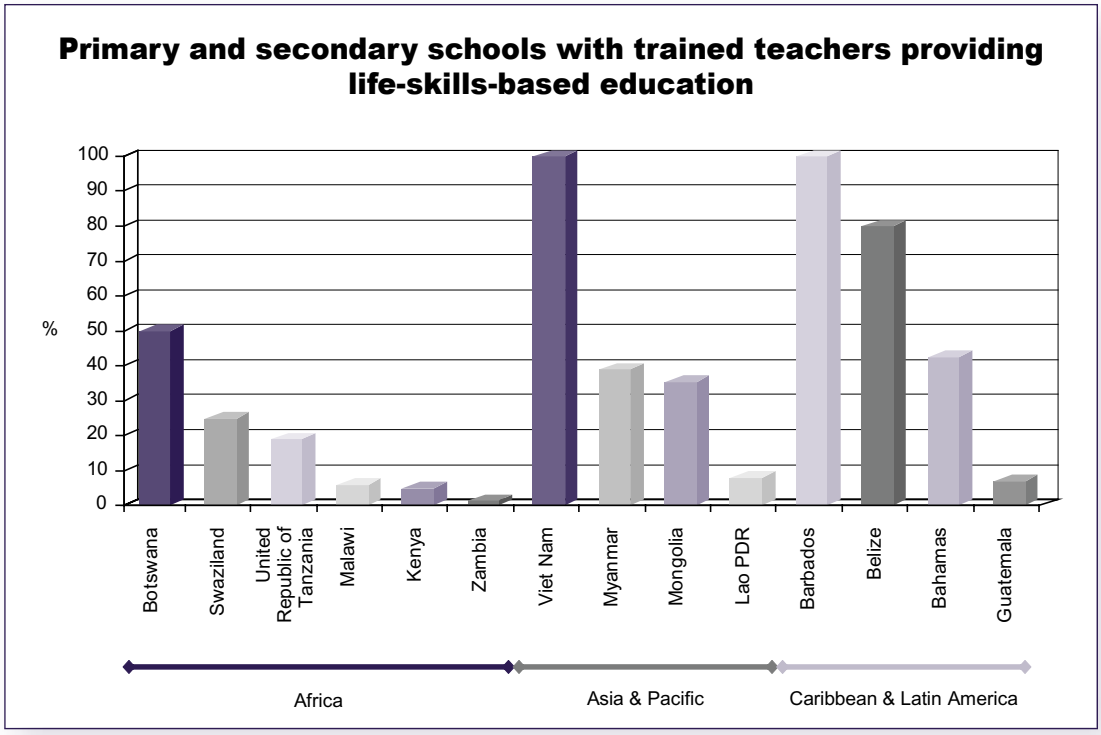
Before embarking on a major effort to engage schools in the response to HIV/AIDS, Botswana undertook baseline studies to inform programme development. On the basis of this research, the country incorporated HIV/AIDS into subject curricula at all levels, produced self-instructional booklets in Setswana and English, introduced psychosocial counselling in educational institutions, and trained all primary and secondary school teachers in life-skills-based education.

In addition, the country has initiated the Teacher Capacity-Building Programme, a national distance learning television programme that targets teachers and students in primary, secondary and tertiary institutions. Modeled on Brazil's successful TV Escola, the programme provided TV sets and video machines to 325 of the country's 979 schools, technical colleges and educational centres.

- ***Asia and Pacific***. In ***Thailand***, the Ministry of Education has ensured that information about HIV/AIDS is incorporated into school curricula at all levels and that at least one teacher from each of the country's 33,200 public and 421 private schools has been trained to provide HIV-related educational instruction. More recently, Thailand has geared its school-based interventions towards a participatory learning and life-skills approach, with a core group of educators working with schools throughout the country to assist in integration of life-skills-based programmes into educational efforts. After introducing HIV/AIDS education into schools in 1991, the Vietnamese Ministry of Education and Training, in collaboration with UNICEF and certain international NGOs, began, in 2002, to pilot-test a 'healthy life and life-skills' educational programme in schools, which seeks to equip students with the skills they need to negotiate decisions on drug use and HIV/AIDS.

- ***Latin America and the Caribbean***. In this region, ***Barbados*** and ***Belize*** have made the most progress in exposing students to life-skills-based HIV/AIDS education. In ***Barbados***, life-skills-based HIV/AIDS education begins in primary schools and continues in later years with age-appropriate methods and content. Drama, poetry, dance and other unconventional methods are used to reach school children with life-skills-based programming. In addition, the country has launched a 'Champions' programme, involving entertainers and sports personalities, who facilitate an HIV/AIDS module and interact with students in primary schools.

- ***Eastern Europe and Central Asia***. The five countries responding from this region have primarily focused on secondary schools, with limited life-skills-based programming at primary level. Of the five responding countries, the ***Russian Federation*** appears most advanced in its integration of life-skills-based programmes.



2. Workplace HIV/AIDS control

Percentage of large enterprises/companies that have HIV/AIDS workplace policies and programmes

The Declaration of Commitment calls on companies to enact policies that reduce stigma and prevent discrimination on the basis of HIV infection in recruitment, promotion, termination and benefits. The Declaration further encourages companies to adopt comprehensive HIV/AIDS workplace policies that provide basic information on HIV/AIDS, educate workers about specific work-related transmission hazards and safeguards, promote condom use, provide access to voluntary counselling and testing and to STI diagnosis and treatment, and provide HIV/AIDS-related drugs. These provisions are consistent with the ***ILO Code of Practice on HIV/AIDS and the World of Work***, also adopted in June 2001, which provides guidance to governments, employers and workers' organizations on development and implementation of workplace policies and programmes on HIV/AIDS.

As explained in Section I, UNAIDS, in response to Global Indicator 3, surveyed major transnational companies to determine how many had adopted HIV/AIDS workplace policies and programmes. To obtain information on the distribution of such workplace programmes among countries, additional studies were conducted in selected countries to assess the degree to which industry was serving as a full partner in the national responses to HIV/AIDS.

Countries were asked to provide information in workplace policies in large public and private companies. Of the 103 countries that provide HIV/AIDS-related information on national responses, only 26 provided information on workplace policies and programmes – 17 in sub-Saharan Africa, 5 in Asia and the Pacific, 4 in Latin America and the Caribbean, and none from

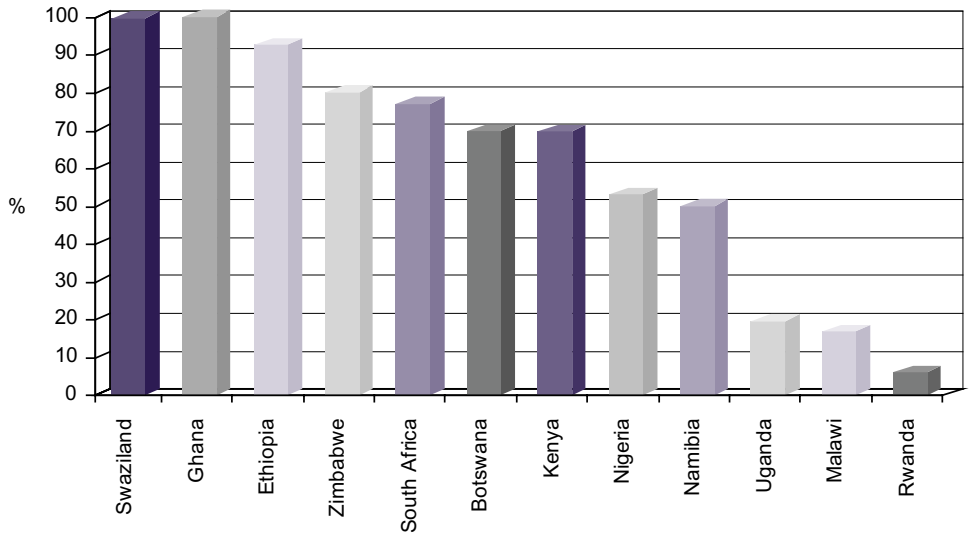
other groupings (North Africa and the Middle East, Eastern Europe and Central Asia, and high-income countries).

Country responses are summarized in Annex 4. In general, responses indicate that few companies have adopted comprehensive workplace policies to address HIV/AIDS, although many enterprises have adopted various components of the recommended workplace framework. Companies commonly provide HIV/AIDS education to workers and often distribute condoms. Some have formally prohibited HIV-related discrimination and facilitated workers' access to VCT and STI diagnosis and treatment. Few large companies, however, provide coverage for HIV/AIDS drugs. Interestingly, private companies appear more likely than public enterprise to have adopted key components of recommended HIV/AIDS workplace policies.

Increasing workplace commitment in Indonesia

The Indonesian Employers' Association, UNAIDS, ILO and the Kusuma Buana Foundation initiated a campaign for HIV prevention in the workplace in 1997, and around 200 companies have since participated. Approximately 200 companies have used HIV/AIDS education modules prepared by the Indonesian AIDS Foundation and the Kusuma Buana Foundation. In February 2003, the Tripartite Declaration of Commitment to combat HIV/AIDS in the world of work was signed by the Minister of Manpower, the chairmen of the Indonesian Chamber for Trade and Industry, and the Indonesian Employers' Association and several chairmen of trade unions. An Indonesian Business Coalition to combat HIV/AIDS has also been established.

Percentage of large companies with HIV/AIDS policies



Data from UNGASS Country Reports based on a survey of the 30 largest employers

3. Sexually transmitted infections: comprehensive case management

Percentage of patients with STIs at health-care facilities who are appropriately diagnosed, treated and counselled

Untreated STIs significantly increase (by several orders of magnitude) the efficiency of HIV transmission. Accordingly, timely diagnosis and treatment of STIs has long been recognized as a pillar of effective HIV prevention. Unfortunately, STI services are often inaccessible in many parts of the world.

In a 2001 review of developing countries and countries in transition, WHO estimated that fewer than 18% of people in need of STI services were able to obtain them. Achievement of the Declaration's ambitious HIV-prevention targets will require rapid scaling-up of STI control activities.

Only limited data are currently available regarding this indicator. According to information provided by countries in 2003, fewer than 10% of countries have conducted health facility surveys to assess the percentage of STI patients who are appropriately diagnosed, treated and counselled for STIs. In the absence of facility surveys, countries provided their own estimates for STI case management, based on other monitoring data.

Available information is summarized in Annex 5. Of particular note are results from sub-Saharan Africa, where only two of the eight respondent countries have STI coverage greater than 50% (***Mauritius*** and ***Zimbabwe***). Only limited information is available for Eastern Europe and Central Asia, where rapid increases in syphilis and gonorrhoea are combining with earlier onset of sexual debut to create conditions for the rapid spread of HIV. However, the few reports received from ***Belarus***, ***Kazakhstan***, ***Kyrgyzstan***, ***Slovakia*** and ***Tajikistan*** show that specific efforts to improve STI case management led to scores of over 75%.

4. Prevention of mother-to-child transmission: antiretroviral prophylaxis

Percentage of HIV-infected pregnant women receiving a complete course of antiretroviral prophylaxis to reduce the risk of MTCT

Each year, an estimated 800,000 infants contract HIV in the womb, during delivery or as a result of breastfeeding. In 1999, researchers reported that a single dose of nevirapine to HIV-positive mothers and their newborns reduced the risk of transmission by 50% or more. When combined with efforts to increase the accessibility of voluntary counselling and testing, improve access to prenatal care, and counsel mothers about breastfeeding, nevirapine has the potential to dramatically reduce the number of children who contract HIV at the outset of their lives. PMTCT programmes also provide an ideal bridge to longer-term care and treatment for HIV-positive mothers.

Although the Declaration of Commitment prioritizes rapid implementation and scaling-up of programmes to prevent mother-to-child transmission, many countries are experiencing difficulty in increasing access to PMTCT services. Countries were asked to report on PMTCT programme monitoring data as of December 2002. UNAIDS supplemented information supplied by countries with country-specific data available through WHO.

Coverage figures as of December 2002 are summarized in Annex 6. Some countries with severe epidemics, such as ***Botswana*** (with 34.3% coverage), have made important strides in reaching HIV-positive pregnant women who avail of public health services with ARV prophylaxis. In general, however, the picture is one of starkly limited access to this potentially life-saving intervention.

In other regions, PMTCT services are similarly either completely unavailable or accessible only to a small fraction of the population. In ***Guyana*** and ***Haiti***, the two most heavily affected countries in the Caribbean region, PMTCT coverage is 0.1% and 0%, respectively. In ***Cambodia*** and ***Myanmar***, two of the hardest-hit countries in Asia, fewer than 3% of pregnant women currently have access to ARV prophylaxis.

5. HIV treatment: antiretroviral combination therapy

Percentage of people with advanced HIV infection receiving antiretroviral combination therapy

ART can dramatically reduce HIV-related morbidity and mortality and improve quality of life. This is particularly true in developed countries, where ARV access is almost universal. Between 1995 and 2001, for example, as ART uptake accelerated in the US, HIV-related deaths declined by more than 83%.

- ***Sustained health benefits from ART.*** A recent study analysing data on nearly 10,000 patients in 70 European health centres suggests that the initial drop in mortality and morbidity after the introduction of Highly Active Antiretroviral Therapy (HAART) has been sustained and that the potential long-term adverse effects associated with HAART have not altered its effectiveness in treating AIDS. The incidence of AIDS or death fell after September 1998 by 8% per six-month period, indicating that medical outcomes were improving as clinicians gained greater experience in managing HAART and as additional ART regimens have come on line.

- ***Opportunities to integrate prevention and treatment.*** Accessible treatment also provides new opportunities for prevention, creating powerful incentives for voluntary counselling and testing and offering opportunities to direct targeted prevention interventions towards people living with HIV/AIDS. Greater treatment access may contribute to the reduction of HIV-related stigma and to the mobilization of people living with HIV/AIDS, of their families and of their communities.

- ***Limited ART access in low- and middle-income countries.*** Although it is estimated that 5–6 million adults in developing countries are currently in need of ARV drugs, UNAIDS and WHO estimate that only 300,000 people in low- and middle-income countries (800,000 worldwide) are currently receiving such therapies. Brazil accounts for more than one-third of the patients in developing countries who are currently receiving the drugs.

Expanding access to HIV/AIDS drugs in Brazil

The potential global impact of scaled-up treatment access is apparent from experience in Brazil, which began providing ART through its public health service in 1996. According to information provided by Brazil, the country currently provides ART to 119,500 patients. Since initiation of its ART treatment programme, Brazil has seen AIDS-related mortality decline by 50%, averting an estimated 90,962 deaths. Cost savings in reduced hospital admissions and averted treatment costs for opportunistic infections are estimated at more than US$1 billion. Hospital admissions, TB incidence, and rates of opportunistic illnesses have significantly declined. After more than six years of ART access through the Brazilian public health system, levels of ART resistance in Brazil are still significantly lower than levels reported in North America and Western Europe. According to national authorities, key factors in the success of Brazil's programme include effective social mobilization, representation of affected communities, and the active engagement of NGOs and civil society.

- ***Important national initiatives.*** A number of countries are following Brazil's lead in expanding access to ART.
  - ART access in ***Uganda*** has broadened from 7 centres in 2000 to 23 in 2002, benefiting about 10,000 people. Currently, however, even the markedly reduced costs of ART drugs at Ugandan clinics are beyond the means of most patients. To increase the affordability and accessibility of ART, the Ministry of Health has established a national committee that has been charged with the development, in consultation with key stakeholders, of a national plan for scaling up ART access. Subcommittees of this national group focus on policy development, logistics, clinical care, advocacy and finances. To help Uganda overcome infrastructure barriers to scaling up, the Academic Alliance for AIDS Care and Prevention in Africa, Pfizer International, and Makerere University are working together to create a state-of-the-art infectious disease institute.
  - ***Thailand*** is moving to enhance access to ART. Currently, the Government Pharmaceutical Organisation (GPO) is producing several generic ARV drugs. On average, Thailand estimates it needs to spend US$500 per patient each year to treat a case of advanced HIV infection. By combining national expenditures with assistance from the Global Fund, the country has recently announced its plan to increase ART access from 2000 patients in 2002 to 13,000 by September 2003. A proposal to make ART access universally available, reaching an estimated 50,000 – 60,000 patients during the fiscal year that begins in October 2003, is currently being reviewed and considered.
  - ***Botswana*** has committed to making ART available nationwide over the next five years.
  - ***China*** intends to establish 100 demonstration treatment sites in 100 counties with high prevalence.
  - ***Moldova*** has developed a national ART protocol based on WHO guidelines and is working with UNAIDS to obtain drugs at the most favourable prices.

— In 2002–2003, some ***Caribbean*** and ***Latin American*** countries negotiated substantial reductions in the prices charged by seven generic and one brand-name manufacturer, allowing the countries to save up to US$120 million per year, which, in turn, will permit the enrolment of an additional 150,000 patients in ART treatment programmes.

- ***Increasing donor support for ART.*** These and other national efforts to bring ART access to scale will likely benefit, in 2003 and beyond, from significantly increased levels of financial and technical support from the international community. The World Bank has committed to prioritizing treatment programmes in its lending efforts, and ART projects approved by the GFATM are beginning to receive substantial new resources in 2003. The US Government has embarked on a five-year initiative to expand ART access to 2 million people in 14 hard-hit countries in Africa and the Caribbean, and the GFATM estimates that its roster of approved projects will result in ART access for 500,000 patients. Effective implementation of these unprecedented new resources will also benefit from increased technical guidance from WHO, which, in 2002, added ART drugs to its list of essential drugs and published guidelines on scaling up ART programmes in resource-limited settings.

Despite the unprecedented global momentum for treatment scale-up, the challenge ahead remains daunting, as country information provided to UNAIDS makes apparent. Countries were asked to report on ARV therapy programme monitoring data as of December 2002, and UNAIDS supplemented this information by obtaining available country-specific coverage data from WHO offices. The results are summarized in Annex 7.

In sub-Saharan Africa, where WHO estimates ARV coverage at approximately 1%, the greatest success in reaching patients in high-prevalence countries has occurred in ***Botswana*** and ***Uganda***, which report coverage of 7.9% and 6.3% respectively, as of December 2002. Other countries such as Cameroon, Côte d'Ivoire and Nigeria have also recently made efforts to increase ARV coverage. In ***South Africa***, ***Zambia*** and ***Zimbabwe***, by contrast, all of which have infection rates among the world's highest, WHO reports that coverage in the public sector was effectively nil in 2002. Caribbean countries that provided information to UNAIDS report coverage below 1%. In Asia, where more than 7 million people are living with HIV/AIDS, no country exceeded 5% ARV coverage, with several countries reporting especially low rates.

International collaboration to expand treatment access

The International HIV Treatment Access Coalition (ITAC) is a coalition of people living with HIV/AIDS, HIV/AIDS advocates, NGOs, governments, foundations, the private sector, academic and research institutions, and international organizations. Their shared goal is expanding access to appropriate HIV treatment for all people living with HIV/AIDS, in keeping with the goals of the Declaration of Commitment. ITAC will use and create all possible forums to mobilize support for expanded access to HIV/AIDS treatment and care. The coalition also plans to pursue all possible opportunities to promote research and development for better drugs and to accelerate efforts to make drugs available and affordable to developing country populations. The coalition's power lies in the complementary skills and capacities of its partners. Different members will contribute to different elements of the coalition's plan of action.

6. Injecting drug users: safe injecting and sexual practices

Percentage of injecting drug users who have adopted behaviours that reduce transmission of HIV (core indicator)

Percentage of injecting drug users reached by prevention services (alternative indicator)

The Declaration of Commitment on HIV/AIDS calls for the provision of essential prevention services to reduce the risk of HIV transmission through injecting drug use. Recommended services in the Declaration include expanded access to essential commodities, including, among others, sterile injecting equipment; harm-reduction efforts related to drug use; expanded access to voluntary and confidential counselling and testing; and early and effective treatment of sexually transmitted infections.

- ***Significant contributor to spread of HIV***. To date, more than 135 countries have reported injecting drug use among their populations, and more than 110 of them report HIV infections among those injecting drugs (UNODC). It is estimated that, worldwide, 5–10 million people inject drugs, and that 5-10% of all new HIV infections globally result from the sharing of contaminated injecting equipment. Once the virus is introduced into groups of injecting drug users, countries may face explosive growth in HIV infection. In many countries in Europe, Asia, the Middle East and the Southern Cone of Latin America, sharing of unsterile injecting equipment is the primary mode of HIV transmission, accounting for 30-90% of all reported infections. In some countries, HIV epidemics that have begun among drug injectors and their sexual partners have spread to the general population.

- ***Effective prevention is feasible***. Experience from numerous countries, however, confirms that reducing the risk of HIV/AIDS among injecting drug users is an achievable goal. Appropriately designed prevention programmes can reduce the transmission rate of HIV and other blood-borne diseases such as hepatitis B and C, as well as sexually transmitted infections. Even when HIV/AIDS is well established in a community or area, prevention programmes can significantly limit the further spread of HIV.

  Such prevention programmes usually consist of a package of interventions, including referral to a variety of treatment options (such as abstinence-oriented treatment and drug substitution), access to clean needles and syringes, AIDS education, life-skills training, condom distribution, and voluntary confidential counselling and testing.

- ***Limited data on IDUs.*** Essential information on injecting drug use (such as the number of injecting drug users, the rate of HIV infection among them and coverage by health-care services) is not available from key countries at this stage. Twenty countries in which the sharing of injecting equipment among drug users constitutes a significant route of HIV transmission have been specifically approached to provide information on one or both of the above-mentioned UNGASS indicators. Of these 20 countries, 9 provided information on the coverage indicator (5 from Asia and the Pacific, 1 from Latin America, 1 from North Africa and the Middle East, and 2 from Eastern Europe and Central Asia) and 3 reported on safe behaviour.

Most of those countries that failed to report indicated that data are not available at this stage, and that appropriate information collection mechanisms have not yet been established. Moreover, those countries that provided information on the indicators reported various difficulties in collecting comprehensive information, particularly incomplete data sets and inappropriate data collection mechanisms, such as the absence of opportunities to pool data from various government departments and from nongovernmental organizations. Countries that reported on the coverage indicator also provided information on the estimated number of injecting drug users (see Annex 18).

- ***Low coverage rates for IDU services***. Overall, almost half of the nine respondent countries report coverage with services for injecting drug users of less than 5%. The estimated number of injecting drug users in these countries ranges between 20,000 and close to 800,000.

  — ***Asia.*** In South-East Asia, the coverage ranges from 1.5% in ***Indonesia*** to 62% in Viet Nam. For these countries, the estimated number of injecting drug users totalled approximately 650,000, with national infection rates ranging from 7% (China) to 41% (Viet Nam). The estimated number of injecting drug users in the two countries from South Asia – ***Pakistan*** and ***Nepal*** – equaled 80,000; the coverage scores were 0.4% (Pakistan) and 21.9% (Nepal), and the HIV infection rate for injecting drug users was estimated only for Nepal, at 40%.

  — ***Eastern Europe and Central Asia***. The two countries that responded from Eastern Europe and Central Asia reported coverage of 1.8% (***Belarus***) and 2.2% (***Romania***). The total number of injecting drug users in these countries is 80,000; information on the national infection rate was available only for Belarus (6.7%).

  — ***Latin America***. For Latin America, information was available only for ***Brazil***, reporting coverage of 10.5%, an estimated number of injecting drug users of 800,000, and a national infection rate among injecting drug users of 0.4%.

  — ***Middle East***. For the Middle East region, information was available for ***Iran***, which reported 136,000 injecting drug users and 0.6% coverage.

7. Young people's knowledge about HIV prevention

Percentage of young people aged 15–24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission

The Declaration of Commitment establishes as a global target the ability of 90% of young people by 2005, and 95% by 2010, to have access to sufficient information, education and services to reduce their vulnerability to HIV/AIDS. Data assembled through national household surveys have allowed UNAIDS to assess young people's understanding of key issues related to HIV transmission. Although knowledge alone does not automatically produce sustained behavioural change, it is an essential prerequisite for the adoption of healthy behaviours.

- ***Focus on women.*** In general, information compiled by UNAIDS derives from Demographic and Health Surveys (DHS) and from UNICEF's Multiple Indicator Cluster Surveys (MICS). These surveys focus primarily on women, who, according to available data, generally have lower knowledge levels than men. Both the DHS and

MICS surveys use two-stage stratified samples with similar questionnaire designs, facilitating comparison of data from the two surveys. For most countries, available information is from 2000, which may not accurately reflect knowledge levels in 2003.

National Programme and Behaviour Indicator 7 is a composite of responses by young people to the following set of prompted questions:

— Can the risk of HIV transmission be reduced by having sex with only one faithful, uninfected partner?

— Can the risk of HIV transmission be reduced by using condoms?

— Can a healthy-looking person have HIV?

— Can a person get HIV from mosquito bites?

— Can a person get HIV by sharing a meal with someone who is infected?

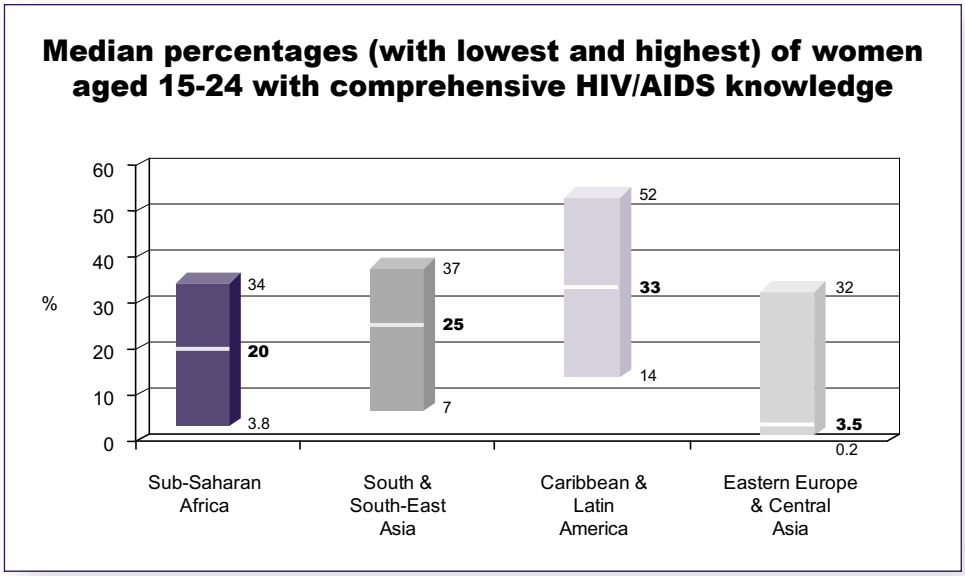
■ ***Low knowledge levels.*** Annex 8 summarizes available data provided by countries, as well as country-specific information gathered from global databases, on the comprehensiveness of young women's HIV-related knowledge in 2000. Annex 9 identifies the percentage of young women (aged 15-24) with accurate knowledge of HIV-prevention methods. Annex 10 summarizes the percentage of young women who exhibit no major misconceptions about HIV/AIDS.

Even accounting for the likelihood that HIV-related knowledge has grown in many countries since 2000, the information summarized in these annexes demonstrates a disturbingly low level of basic knowledge about HIV/AIDS in a highly vulnerable population. Of 38 countries surveyed, only 7 have levels of comprehensive knowledge higher than 30%.

■ ***Regional variations in knowledge levels.*** Because sub-Saharan Africa was oversampled in these surveys, regional comparisons are difficult. Nevertheless, it is noteworthy that young women in Latin America and the Caribbean tend to exhibit substantially higher knowledge levels than their counterparts in other regions.

Within regions, substantial variations are apparent between countries. While nearly two-thirds of young women in ***Cambodia*** understand that condom use reduces the risk of transmission, less than one-quarter of young women in Indonesia do. Likewise, young women in ***Cuba*** are twice as likely as young women in ***Haiti*** to recognize the protective effect of condoms. In sub-Saharan Africa, 84% of young women in ***Malawi*** understand that a healthy-looking person can have HIV, compared to 22% in ***Niger***, while in ***Swaziland*** young women are nearly three times more likely than their counterparts in the ***Central African Republic*** to realize that HIV cannot be transmitted through mosquito bites or the sharing of food.

As a general rule, the proportion of young women reporting accurate knowledge of prevention methods is higher in countries heavily affected by HIV/AIDS, with the exception of ***Haiti***, where knowledge levels are strikingly low. Knowledge levels also tend to be higher in urban than in rural areas. With respect to prevention methods, young women generally are likely to recognize monogamy as a more effective prevention method than condom use.



8. Young people's risk-reduction behaviour

Percentage of young people aged 15–24 reporting the use of a condom during the last sexual intercourse with a non-regular sexual partner

Median age at first sex

Percentage of 15–24-year-olds who have been sexually active in the last 12 months and have had sex with a non-marital, non-cohabiting partner in the same period

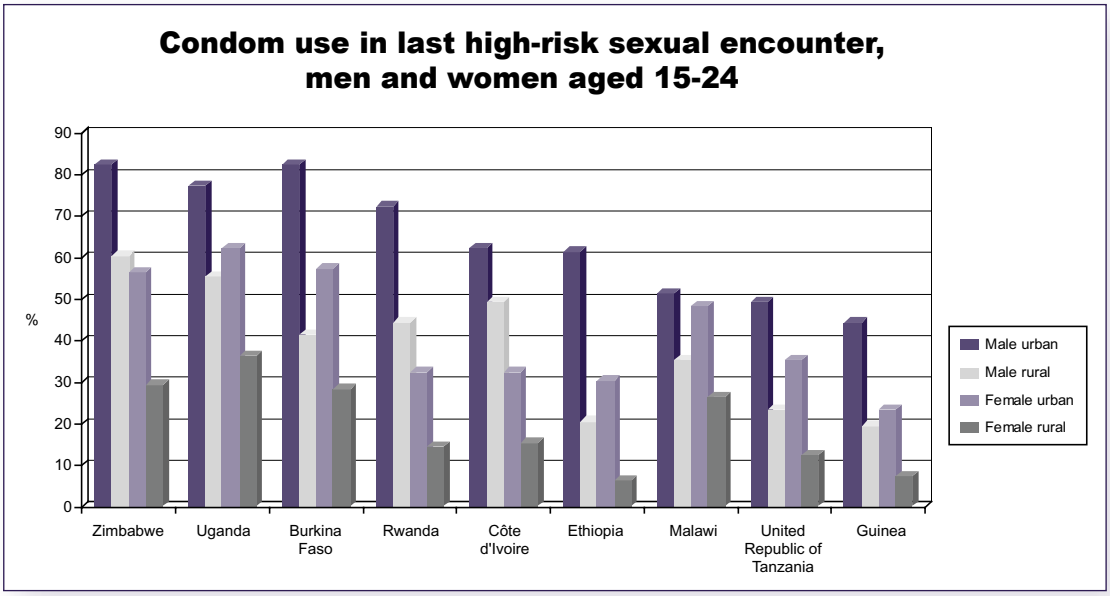
Using results of established behavioural surveys, countries were asked to report on sexual behaviour trends among young people (15–24). Annex 11 summarizes information on the percentage of young people in selected countries who report having used a condom the last time they had sex with a non-regular partner.

Because sub-Saharan Africa is both the most heavily affected region and one where rates of sexual HIV transmission among young people are high, additional analyses from existing surveys were performed on countries in that region. Annex 12 describes the percentage of young people (15–24), stratified by sex, who report having had higher-risk sex during the year before the survey. Annex 13 summarizes median age of first sex for young people in sub-Saharan Africa, stratified by sex and according to rural or urban residence.

Survey results indicate that young men are more likely than young women to report use of a condom with non-regular partners. This is partly due to the fact that young women are unable to discuss condom use for fear of insulting or angering their partners or of being labelled as promiscuous. Data also suggest that condom use is higher in urban than in rural areas and that safer sexual practices among young people vary considerably between countries. In sub-Saharan Africa, for example, condom use is highest in ***Botswana*** where it is 88% for men and 75% for women and the lowest in ***Chad*** where it is 2% for both men and women. Young men in ***Zimbabwe*** are more than twice as likely to use condoms than are young men in ***Mali***, and young women in ***Uganda*** are more than three-and-a-half times more likely to use condoms than are their counterparts in the ***Democratic Republic of the Congo*** and ***the Republic of the Congo.***

Young men are more likely to report having had higher-risk sex in the prior year. Young men in ***Kenya*** are more than twice as likely to have had riskier sex in the past year than are young men in ***Rwanda***. While only 7% of young women in ***Ethiopia*** report higher-risk sex in the last 12 months, more than one-half of young women in ***Côte d'Ivoire*** report such behaviour.

Helping young people postpone penetrative sexual activity until they have developed the necessary personal and social skills to protect themselves is an important goal in HIV prevention. In countries in sub-Saharan Africa, as summarized in Annex 13, between 15% and 20% of young men and women report having had sexual intercourse before the age of 15, with young women reporting earlier median age of first sex than males. Here, too, age of initiation of sexual activity varies significantly between countries – from 16 to 22.1 for men, and from 16.3 to 20.8 for women.



9. Orphans' school attendance

Ratio of current school attendance among orphans to that among non-orphans aged 10-14

In accordance with the Declaration of Commitment, countries are required to have developed, by 2003, and to implement, by 2005, policies to support children orphaned by AIDS and other children affected by the epidemic. Enrolment in school is recognized by the Declaration as a key component of orphan support programmes.

The provisions in the Declaration on orphans are in keeping with strategies and principles identified to improve the socioeconomic and emotional support available to children orphaned or otherwise made vulnerable by HIV/AIDS. One of the central strategies identified by UNAIDS Cosponsors is "to strengthen the capacity of children and young people to meet their own needs", which largely depends on the protection and expansion of educational opportunities for orphans and other vulnerable children.

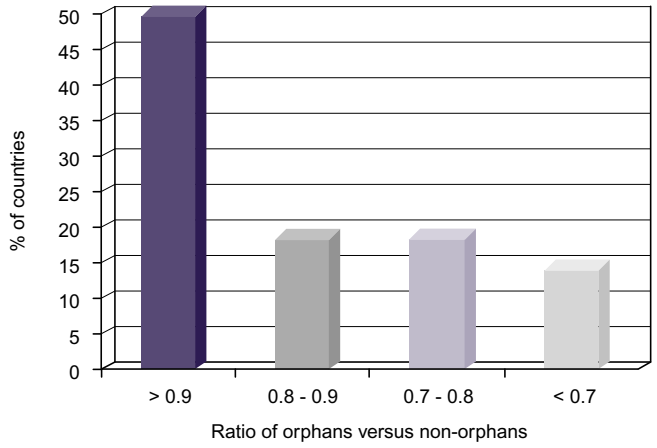
To track school attendance of orphans in comparison to non-orphans (a stark indicator of educational disadvantages potentially associated with orphanhood), UNAIDS relied on existing household surveys – primarily the UNICEF MICS 2000. Findings from these surveys are summarized in Annex 14. Although this table focuses on sub-Saharan Africa as the most

heavily affected region, the absolute numbers of orphans in Asia and parts of the Caribbean are substantial and require immediate attention, as well, by governments and donors.

In most sub-Saharan African countries, children (aged 10-14) who lost both parents were less likely to be in school than those who lived with one of their parents. Significantly, however, the fact that the ratio is almost 1:1 in half the countries in sub-Saharan Africa suggests strong commitment on the part of these countries to assist vulnerable children. Caution in interpreting these findings is warranted, as figures may understate the extent of disadvantage associated with orphanhood by omitting street children and institutionalized children, who are more likely to be orphaned than those living in households. Gender analysis on male/female orphan ratio does not seem to indicate any consistent pattern suggesting a male/female discrimination. Lower orphan school enrolment seems to be associated with low general school attendance rates.

Several African countries have taken action to expand support services for children orphaned or otherwise made vulnerable by HIV/AIDS. In ***Lesotho***, where 40,000 children receive full tuition subsidies in primary and secondary schools, the First Lady has made support for orphans a personal and governmental priority. ***Mozambique*** is currently finalizing a national strategy for the protection and care of orphans, and partnership between government and grass-roots organizations have been forged to extend support to community initiatives in this area.

Percent distribution of sub-Saharan African countries by ratio of school attendance – orphans versus non-orphans



IV. National Impact Indicators

1. **Percentage of young people aged 15-24 who are HIV-infected (Target: 25% reduction in most affected countries by 2005; 25% reduction, globally, by 2010)**
2. **Percentage of HIV-infected infants born to HIV-infected mothers (Target: 20% reduction by 2005; 50% reduction by 2010)**

1. Reduction in HIV prevalence

Percentage of young people aged 15-24 who are HIV-infected (core indicator for countries with generalized epidemics)

The percentage of young pregnant women aged 15-24 attending antenatal clinics in HIV sentinel surveillance sites in the capital city, other urban areas and rural areas is used as a proxy for the core indicator on HIV prevalence among youth. Community surveys of HIV prevalence in various settings among young men and young women have shown that sentinel HIV surveillance among pregnant women aged 15-24 provide robust estimates for young people.

The epidemic remains most severe in Southern Africa, with extremely high HIV prevalence rates among pregnant women aged 15-24 reported in a number of countries, such as ***Swaziland*** (39%), ***Botswana*** (32%), ***South Africa*** (24%), ***Kenya*** (22%), ***Namibia*** (18%), ***Zimbabwe*** (18%) and ***Malawi*** (18%). In East Africa, prevalence in this population continues to decline in ***Uganda*** – from 30% in the early 1990s to 9% in 2002. In West and Central Africa, national prevalence rates remain relatively low, although there is evidence of recent HIV spread in countries such as ***Cameroon*** (12%). (For more details, see Annex 15.)

The epidemic in Latin America and the Caribbean is well established. A total of 12 countries in the region have an ***estimated*** HIV prevalence of 1% or more among pregnant women. In other regions, national prevalence is relatively low, as the epidemic is mostly concentrated in specific populations. Exceptions to this rule include ***Cambodia***, ***Djibouti***, ***Myanmar*** and ***Thailand***, where rates among pregnant women exceed 1%.

1a HIV prevalence among sex workers, injecting drug users and men having sex with men (alternative indicator for countries with low and concentrated HIV epidemics)

HIV prevalence among high-risk groups is obtained from specific serosurveys among those population groups. Evidence indicates that infection rates are often extremely high in key vulnerable populations.

- ***Sex workers***. In sub-Saharan Africa, prevalence among sex workers often exceeds 50%, with countries such as ***Ethiopia, Zambia, South Africa*** and ***Ghana*** reporting rates as high as 74%, 69%, 50.5% and 50% respectively (see Annex 16). Of the 11 countries in the Asia-Pacific region for which recent data on HIV prevalence among sex workers are available, three have extremely high rates: ***Myanmar*** (38%), ***Nepal***

(36%), and ***Cambodia*** (29%). In North Africa and the Middle East, ***Djibouti*** remains the most affected country, with HIV prevalence among pregnant women in major urban areas reaching 2% and, among sex workers, as high as 27.5%.

- ***Injecting drug users.*** Numerous countries report concentrated epidemics among injecting drug users (see Annex 17). In Asia, HIV prevalence among IDUs is extremely high in certain parts of ***China*** (40%), ***India*** (68%), ***Indonesia*** (50%), ***Viet Nam*** (80%), ***Myanmar*** (70%), ***Nepal*** (50%) and ***Thailand*** (85%). In ***Brazil***, where prevalence among IDUs is as low as 1.9% in some areas and as high as 42% in others, prevention programmes appear to be bearing fruit, as reflected in substantial declines in HIV prevalence among IDUs in several regions.

  Eastern Europe and Central Asia continues to experience the fastest-growing epidemic in the world, mainly localized among injecting drug users. The ***Russian Federation*** remains at the forefront of the epidemic with an HIV prevalence among IDUs reaching almost 60% in some areas. However, many other countries are now experiencing rapidly emerging epidemics. ***Ukraine*** remains the most affected country not only in the region but in all of Europe; its HIV prevalence among IDUs ranges between 8% and 74%.

Reducing injecting drug users' vulnerability to HIV/AIDS in Iran

The notable growth in HIV infection among IDUs in Iran has triggered responses from provincial and central governments, who have joined with academic experts and health-care providers to create an innovative model that integrates HIV/AIDS care, STI treatment, and drug use services in Kermanshah. This clinic-based programme aims to reduce the stigma associated with HIV/AIDS and drug use, engage families and partners of IDUs, and involve people living with HIV/AIDS. The UN Theme Group on HIV/AIDS in Iran reports that the project has succeeded in delivering much-needed services to a highly vulnerable population and in increasing public support for harm-reduction efforts aimed at IDUs.

- ***Men who have sex with men***. Information is extremely limited on HIV prevalence among men who have sex with men (MSM), although evidence in various countries indicates that infection rates are often high in this vulnerable population. In Latin America and in high-income countries, MSM account for the single largest share of HIV infections. In seven countries in Central America, surveys of MSM reveal infection rates between 8% and 18%, while separate surveys in ***Argentina***, ***Brazil***, ***Mexico*** and ***Peru*** identify prevalence rates ranging from 11% to 18%. In ***Cambodia***, ***India*** and ***Thailand***, similar surveys have revealed HIV infection rates of 14%, 20% and 15%, respectively.

2. Reduction in mother-to-child transmission

Percentage of HIV-infected infants born to HIV-infected mothers

The percentage of HIV-infected infants born to HIV-infected mothers is calculated using PMTCT programme coverage data.

As seen in the previous section on National Programme and Behaviour Indicators, antiretroviral treatment during pregnancy and birth has been implemented only on a small scale. This low coverage leads to high rates of HIV prevalence among newborn babies, as shown in Annex 18. Of the 17 countries in sub-Saharan Africa reporting on PMTCT, 12 have almost no ARV prophylaxis programme, with HIV prevalence among newborn babies of infected mothers reaching 25%.

In Latin America and the Caribbean, apart from ***Argentina***, ***Belize***, ***Brazil*** and ***Uruguay***, where ART prophylaxis strategy is showing some results, most other reporting countries have almost no PMTCT programme. HIV prevalence in these countries among newborns ranges between 23% and 25%.

V. Achieving the Declaration of Commitment targets: challenges ahead

In reporting on progress in implementing the Declaration of Commitment, countries identified numerous barriers to a more effective and comprehensive response to the HIV epidemic. In addition to insufficient resources, several challenges were especially apparent, underscoring the need for capacity development.

The following four challenges to achieving the UNGASS targets were among those most commonly cited by reporting countries:

- Insufficient financial resources to implement and scale up interventions
- Lack of human resources and technical capacity in many areas of HIV programming, especially at local level
- Stigma and discrimination
- Weak monitoring and evaluation systems

1. Insufficient financial resources to implement and scale up interventions

Over 50% of countries cited insufficient financial resources as a crucial barrier to implementation and scale-up of their HIV/AIDS programmes and attaining the targets set forth in the Declaration of Commitment. As noted earlier, the growing financial commitment of bilateral donors, multilateral entities, key foundations and affected countries themselves will likely help to at least partially close this resource gap. In its report on implementation of the Declaration, ***Haiti*** recommends that a legal and constitutional framework be put in place to ensure appropriate budgetary allocation of public finances to HIV/AIDS. In addition to development of resource mobilization capacities at country level, several countries cited the need to implement effective accountability and tracking mechanisms to ensure that resources are used as effectively as possible.

2. Lack of human resources and technical capacity in many areas of HIV programming, especially at local level

One in three countries report a need for increased human resources to tackle HIV/AIDS**.** In ***Botswana***, this shortfall in human resources has become a major concern, and a human resources plan has been developed to try to address this issue. ***South Africa*** reported that the main challenge to implementation relates to capacity, especially with respect to health workers' clinical skills to manage patients with TB, STIs and opportunistic infections.

Many countries highlight the urgent need to build capacity at local level. In particular, countries frequently cite the importance of strengthening the capacity of NGOs and community workers to implement prevention programmes, especially in rural areas and among vulnerable groups. Numerous countries also noted the need to enhance the capacity of health workers to administer PMTCT drugs, ART and treatment for opportunistic infections.

Countries report that they are responding to capacity limitations in a variety of ways. ***South Africa***, for example, has made additional public funds available to provide training to health workers. In ***Morocco***, multisectoral committees have been established to facilitate the implementation of the National Strategic Plan at local level.

3. Stigma and discrimination

Approximately 25% of countries identify stigma and discrimination as major challenges to implementing the Declaration of Commitment.

China reports that discrimination and prejudice towards people living with HIV/AIDS still exist among medical staff, as reflected in some medical institutions where non-consensual serum tests are carried out on patients and treatment is refused to those testing positive – a practice that violates national regulations. ***Malawi***'s report emphasizes the inadequate recognition and empowerment of organizations of people living with HIV/AIDS to challenge both institutional- and individual-level stigma and discrimination. ***Botswana*** observes that stigma is impeding scale-up of PMTCT, as many women fear enrolling in PMTCT programmes due to fear of negative reactions from their partners.

4. Building monitoring and evaluation capacity

Three-quarters of countries report that monitoring and evaluation (M&E) of national activities and progress remain major challenges, with countries frequently citing their limited information systems and M&E capacity as an impediment to their ability to provide information relevant to the national indicators. In particular, reliable information is frequently lacking with respect to the quality of STI services, HIV workplace policies, and coverage of antiretroviral treatment and PMTCT.

Only 43% of countries report having a national M&E plan, and only 24% report having a national M&E budget to carry out these activities. Although most countries have a dedicated M&E unit (85%) and/or a formal health information system (88%), more than 33% do not have a health information system operational at the subnational level.

Stressing that gender equality and the empowerment of women are crucial in reducing the vulnerability of women and girls to HIV/AIDS, the Declaration of Commitment agreed on several targets aimed at empowering women and girls to protect themselves from HIV infection. In order to assess national progress towards these goals, nine indicators requested data, asking for a breakdown by gender (accurate diagnosis of STIs, ARV coverage, IDUs' sexual practices, young people's prevention knowledge, condom use, higher-risk sex and sexual debut, orphans' school attendance and percentage of young people infected with HIV). Unfortunately, less than one in five countries provided these disaggregated data.

At present, with the current information systems in place, it will be very difficult to assess how far countries have progressed towards achieving these targets unless countries do the following:

- Review their current prevention and care programmes to ensure that they take gender and age into account
- Review their policies to ensure that men and women have equal access to service facilities

- Strengthen data collection systems to incorporate gender-specific data and analyse them according to gender
- Systematically report on gender issues in HIV prevention, including sexual violence, care, and impact mitigation.

Strengthening monitoring and evaluation capacity in Ghana

A national monitoring and evaluation (M&E) plan and framework have been developed as a result of consultations with partners and key stakeholders. Additionally, regional and district monitoring and evaluation focal persons for all 10 regions and 110 districts in the country have been nominated and established. Their roles and responsibilities include the following:

- Document the major activities on HIV/AIDS in the region and prepare quarterly reports on regional HIV/AIDS activities to the Ghana AIDS Commission.
- Arrange dissemination of information on HIV/AIDS at all levels within the region.
- Prepare and implement a regional M&E plan.
- Act as a resource point for information on HIV/AIDS relevant to the region.
- Organize forums for district M&E focal persons to encourage dissemination of best practices.

5. Other challenges

Further to the main challenges discussed above, countries identified a number of other key barriers, some of which are systemic or medium-term, macro-level problems that are seriously hampering efforts to turn the tide on the epidemic. In sub-Saharan Africa, poverty, conflict and famine are increasing vulnerability and mitigating societies' ability to cope with the burden placed on them by HIV/AIDS, which is, in turn, exacerbating poverty and reversing gains made by development efforts. ***Malawi***, in acknowledgement of the cyclical and deadly interplay between chronic poverty, famine and HIV/AIDS, highlighted the challenge of promoting a culture of hope and positive living within this environment. It is widely recognized that new approaches are required to integrate HIV/AIDS into humanitarian responses and key macroeconomic plans.

One in five countries noted that greater political engagement, leadership, social mobilization and partnership development are required to create the right environment to strengthen the fight against HIV/AIDS. Several countries, such as the ***Philippines***, recognized the need to further mainstream HIV/AIDS into existing development programmes and government departments. One in three countries stated that greater coordination among different actors was needed, as well as formalized mechanisms to facilitate the sharing of best practices, mapping out of roles and responsibilities, and coordination of activities. ***Haiti***, for example, recommended the establishment of organized forums of discussion to ensure partnership and dialogue between the government and other sectors of society.

The challenges faced by countries remain ever-present and unconstrained by geography. Even in high-income countries, where many gains were made in the fight against the epidemic, it has been documented that complacency with regard to HIV has taken root in some societies, new

vulnerable groups have emerged, and HIV infections are on the rise once again, prompting the need for innovative approaches to prevention.

A multiplication of vigilance, commitment and efforts is thus needed to overcome these surmountable challenges, in order to attain the targets established in the Declaration of Commitment and to reach the Millennium Development Goal of reversing the epidemic by 2015.

Conclusions and recommendations

Based on the assessment of progress made to date in implementing the targets outlined in the Declaration of Commitment, it is apparent that many countries risk falling short of full compliance. However, the aims of the Declaration of Commitment can still be met. Immediate implementation of a comprehensive set of interventions (see Annex 1) could, by 2010, prevent 29 million new infections and reverse the AIDS epidemic. Therefore, with the required commitment and action, the goal of reducing global prevalence levels by 25% by 2010 can be met. Without this expanded response, we estimate that there will be 45 million new infections by 2010.

Achieving the rapid scale-up in prevention and care interventions needed to achieve this target will require a substantial increase in resources. The cost of the expanded prevention, care and support activity has been estimated to reach at least US$10.5 billion annually by 2005. In addition to this, human capacity to deliver required interventions and an improved infrastructure will need to be developed to meet the demand of expanded services. To meet these challenges, financial and political commitment will be needed. The costs of scaling up prevention programmes are high but any delay will be even more costly.

UNAIDS therefore urges countries to take the following steps to ensure achievement of the agreed targets in the Declaration of Commitment:

1. With support from the highest levels of government, countries should immediately assess their national **policies**, in comparison with the Declaration's provisions for 2003, and accelerate the development and implementation of policies needed to bring countries into compliance with the Declaration.

2. Although **political commitment** to the HIV/AIDS cause has significantly increased in recent years, too few political leaders are aggressively leading national efforts to respond to the epidemic. Assertive political leadership is especially important in Asia and the Pacific and in Eastern Europe and Central Asia, where effective action is immediately needed to prevent a major expansion of HIV/AIDS.

3. Although the response to HIV/AIDS now extends well beyond health ministries in most countries, **engagement of important constituencies** remains inadequate. In particular, countries should prioritize the involvement of people living with HIV/AIDS and of civil society in general. All companies doing business in low- and middle-income countries should adopt the ***ILO Code of Practice on HIV/AIDS and the World of Work***.

4. Momentum for increased **funding** for HIV/AIDS-related efforts in low- and middle-income sources must accelerate. To finance the global response needed to ensure achievement of the Declaration's future commitments, annual funding for HIV/AIDS programmes must increase twofold over current levels by 2005 and threefold by

2007. In addition to financial support for HIV/AIDS programmes, support is urgently required for strategies to build the **institutional capacity** that countries will need to sustain an effective response over the long term. In scaling up financial support for HIV/AIDS-related efforts, donors should prioritize technology transfer, development of technical capacity at country level, and other mechanisms to build long-term national capacity to support an effective response, especially in the areas of resource management and monitoring and evaluation.

5. Countries urgently need to ensure that a comprehensive package of HIV-**prevention services** is implemented and coverage expanded to guarantee access to these services for all vulnerable groups.

6. All countries should develop and implement national strategies to ensure the delivery of comprehensive **care and treatment** to people living with HIV/AIDS. The global community is committed to the provision of ART to 3 million people living with HIV/AIDS by 2005, which would represent about 30-40% of those who would need treatment in that year (as compared with the 5% of those in need currently receiving treatment).

7. Implementation and enforcement of measures to eradicate HIV/AIDS-related **stigma and discrimination** are urgently needed to ensure that new resources and growing political commitment on HIV/AIDS are effectively translated into programmes that can halt and eventually reverse the global epidemic. As envisioned in the Declaration, countries should adopt, implement and enforce national policies that **prevent discrimination** against, and ensure the full enjoyment of human rights by, vulnerable populations.

8. In addition to enacting policies to ensure equal access to services, countries should assess and address laws, policies and practices that increase the vulnerability of **women and girls**. Donors should prioritize programmes to enhance the economic power of women, national governments should promote necessary legal reforms, and international actors should collaborate to eradicate sexual trafficking and other practices that increase the vulnerability of women and girls to HIV.

9. All countries with generalized epidemics should develop and implement national strategies to address the growing number of **children orphaned** and made vulnerable by the epidemic.

10. Urgent international action is needed to respond to crisis conditions that exist in the countries of **Southern and Eastern Africa.** In particular, the loss of institutional capacity in key national sectors demands the engagement of international sectoral partners to assist these countries in addressing the epidemic's growing impact. A broad diversity of donors and stakeholders should work together to help countries bring essential HIV/AIDS programmes to scale.

Annex 1

Standard HIV/AIDS interventions used by UNAIDS to measure resource needs and resource availability in low- and middle-income countries

Prevention interventions

1. Mass media campaigns
2. Voluntary counselling and testing (VCT)
3. Condom social marketing
4. School-based AIDS education
5. Peer education for out-of-school youth
6. Outreach programmes for sex workers and their clients
7. Outreach programmes for men who have sex with men
8. Harm-reduction programmes for injecting drug users
9. Blood safety
10. Public sector condom promotion and distribution
11. Treatment of sexually transmitted infections (STIs)
12. Workplace prevention programmes
13. Prevention of mother-to-child transmission (PMTCT)
14. Post-exposure prophylaxis (PEP)
15. Safe injections
16. Universal precautions
17. Policy, advocacy, administration and research

Care services

1. Palliative care
2. Diagnosis of HIV infection (HIV testing)
3. Treatment for opportunistic infections
4. Prophylaxis for opportunistic infections
5. Antiretroviral (ARV) therapy, including laboratory services for monitoring treatment

Orphan support

1. Community support for orphan care
2. Orphanages
3. School fee support for orphans

Annex 2

List of countries that provided country reports on implementation of the Declaration of Commitment*

Asia & Pacific
Bangladesh
Cambodia
China
Cook Islands
Fiji
India
Indonesia
Lao PDR
Mongolia
Myanmar
Nepal
Pakistan
Papua New Guinea
Philippines
Sri Lanka
Thailand
Viet Nam

Eastern Europe & Central Asia
Armenia
Belarus
Czech Republic
Hungary
Kazakhstan
Kyrgyz Republic
Lithuania
Poland
Russian Federation
Tajikistan
Moldova
Romania
Ukraine
Uzbekistan

High-income countries
Australia
Canada
Finland
France
Germany
Ireland
Luxembourg
Macedonia
Malta
Netherlands
Portugal
Serbia and Montenegro
Spain
Sweden

Latin America & Caribbean
Antigua
Argentina
Barbados
Belize
Brazil
Chile
Colombia
Dominican Republic
El Salvador
Guatemala
Guyana
Haiti
Honduras
Jamaica
Mexico
Nicaragua
Paraguay
Peru
St Kitts & Nevis
Suriname
Ururguay

North Africa & Middle East
Jordan
Lebanon
Morocco
Oman
Qatar
Saudi Arabia
Syria
Turkey

Sub-Saharan Africa region
Benin
Botswana
Burkina Faso
Burundi
Cameroon
Cape Verde
Comoros
Côte d'Ivoire
Democratic Republic of Congo
Ethiopia
Ghana
Kenya
Lesotho
Madagascar
Malawi
Mauritius
Mozambique
Namibia
Nigeria
Rwanda
Seychelles
Sierra Leone
South Africa
Swaziland
Togo
Uganda
United Republic of Tanzania
Zambia
Zimbabwe

*Received before 15 July 2003

Annex 3

Percentage of schools with trained teachers providing life-skills education

Country	Primary (%)	Secondary (%)	Overall (%)	Source of information	Comments
Sub-Saharan Africa					
Botswana			50	PM*	
Cape Verde			0	PM	
Ethiopia	100	77	97	School survey	Only urban public schools and first part of the indicator
Kenya			5	PM	
Malawi			6.2	PM	
Mauritius	100	30			Overall figure could not be calculated
Seychelles	88.5	77	84.5	PM	Only urban
Swaziland			25	PM	
Uganda	100			PM	Only primary & public schools and first part of the indicator
United Republic of Tanzania			19	PM	
Zambia			1.5	PM	
Zimbabwe			75		No source of information provided
South & South-East Asia					
Laos People's Dem. Rep.			7.7	PM	
Mongolia	3.3	67.7	35.5	PM	
Myanmar	32	46.5	39	PM	
Thailand			100	PM	Only first part of the indicator; incorporation of life skills into curriculum under development
Viet Nam	100	100	100	PM & key informants	UNAIDS definition of the indicator not strictly followed
Caribbean & Latin America					
Bahamas	44	41	42.5	PM	
Barbados			100	PM	
Belize			80	PM	
Brazil	41.4			PM	Only primary and urban schools
Dominican Republic			18.8	PM	First part of the indicator
Guatemala			7	PM	
Eastern Europe & Central Asia					
Armenia		15.5			Only secondary schools
Kazakhstan	0	54.7		PM	Overall figure could not be calculated
Kyrgyzstan		13		PM	Only secondary and public schools
Russian Federation			100	PM	
Tajikistan		3		PM	Only secondary schools
North Africa and Middle East					
Jordan		26		PM	Only secondary urban schools
Morocco			28	PM	

* PM= Programme monitoring data from UNGASS country reports 2003

Annex 4

Percentage of large public and private enterprises in selected countries that adopted comprehensive HIV/AIDS workplace policies

Country	Overall* (%)	Source of information	Comments
Sub-Saharan Africa			
Botswana	70	UNGASS CR**	Overall figure provided in the report
Cape Verde	0	UNGASS CR	Overall figure provided in the report
Comoros	0	Workplace survey	Overall figure based on data provided in the report
Côte d'Ivoire	48	UNGASS CR	Overall figure provided in the report
Ethiopia	92.5	Workplace survey	Overall figure based on data provided in the report
Ghana	100	Workplace survey	Overall figure based on data provided in the report
Kenya	70	UNGASS CR	Overall figure provided in the report
Malawi	17.5	Workplace survey	Only public companies
Mauritius	40	UNGASS CR	Overall figure provided in the report
Namibia	49.5	Workplace survey	Overall figure based on data provided in the report
Nigeria	53	UNGASS CR	Overall figure provided in the report
Rwanda	6	UNGASS CR	Overall figure provided in the report
Seychelles	50	Workplace survey	Overall figure based on data provided in the report
South Africa	77	Workplace survey	Overall figure based on data provided in the report
Swaziland	100	Workplace survey	Overall figure based on data provided in the report
Uganda	20	UNGASS CR	Overall figure provided in the report
Zimbabwe	80	UNGASS CR	Overall figure provided in the report
South & South-East Asia			
Laos	97.2	UNGASS CR	Overall figure provided in the report
Philippines	13	Department of Labour & Employment	Overall figure based on data provided in the report
Viet Nam	87.5	Workplace survey	Overall figure based on data provided in the report
Caribbean & Latin America			
Honduras	0.5	UNGASS CR	Overall figure provided in the report
Jamaica	5	UNGASS CR	Overall figure provided in the report
Suriname	24	UNGASS CR	Overall figure based on data provided in the report

* Not all countries were able to complete the national form (NPBI 2). A large number have provided overall figures in the report without stratification of various components. For those that provided disaggregated figures, the overall figure shown in the table represents companies with at least one component of the comprehensive prevention-and-care package.

** CR: UNGASS Country report 2003

Annex 5

Percentage of patients with sexually transmitted infections who are appropriately diagnosed (d), counselled (c) and treated (t)

Country	% STI patients appropriately D/C/T	Source of information
Sub-Saharan Africa		
Botswana	30	UNGASS CR 2003 (1998 survey)
Burkina Faso	4 (D + T) 13 (C)	UNGASS CR 2003
Madagascar	20 (D+T) 44 (C)	UNGASS CR 2003
Mauritius	100	UNGASS CR 2003
Kenya	50	UNGASS CR 2003
Seychelles	37	UNGASS CR 2003
Uganda	21	UNGASS CR 2003
Zimbabwe	57	UNGASS CR 2003
South and South-East Asia		
Cambodia	88	WHO 2002
Viet Nam	38	UNGASS CR 2003
East Asia and Pacific		
Guam	100 D, 34 T, 18 C	Public and private clinic survey 2002
Mongolia	100	UNGASS CR 2003 (Annual report of National Center Communicable Diseases 2002)
Samoa	100	MoH 2002 (all treated and counselled but diagnosis is not lab-based)
Eastern Europe & Central Asia		
Belarus	75	UNGASS CR 2003
Kazakhstan	98	UNGASS CR 2003
Kyrgyzstan	82	UNGASS CR 2003
Slovakia	100	NACP 2002
Tajikistan	76	UNGASS CR 2003
North Africa & Middle East		
Djibouti	16	MoH 2002
Morocco	49	UNGASS CR 2003

UNGASS CR 2003 = Programme monitoring data from UNGASS Country reports 2003
WHO 2002 = 2002 programme monitoring data through WHO country offices
MoH= Ministry of Health
NACP= National AIDS Control Programme

Annex 6

Estimated percentage of HIV-infected pregnant women receiving antiretroviral prophylaxis

Country	Public facilities (%)	Source of information
Sub-Saharan Africa		
Benin	0	WHO 2002
Botswana	34	UNGASS CR 2003
Burkina Faso	< 1	UNGASS CR 2003
Chad	0	WHO 2002
Democratic Rep. of Congo	0	WHO 2002
Ethiopia	< 1	UNGASS CR 2003
Kenya	1	UNGASS CR 2003
Malawi	< 1	UNGASS CR 2003
Mauritius*	100	UNGASS CR 2003
Namibia	7	UNGASS CR 2003
Niger	0	WHO 2002
Nigeria	< 1	UNGASS CR 2003
Seychelles*	100	UNGASS CR 2003
Sierra Leone	0	UNGASS CR 2003
South Africa	< 1	WHO 2002
Uganda	4.6	UNGASS CR 2003
United Republic of Tanzania	0	UNGASS CR 2003
South & South-East Asia		
Afghanistan	0	WHO country office
Cambodia	2.7	NACP 2002
India	< 1	UNGASS CR 2003
Malaysia	0	WHO 2002
Myanmar	2	UNGASS CR 2003
Nepal*	2.1	WHO 2002
Viet Nam	2.3	UNGASS CR 2003
East Asia & Pacific		
Guam*	0	NACP 2002
Mongolia*	0	UNGASS CR 2003
Samoa*	0	MoH 2002

Country	Public facilities (%)	Source of information
Caribbean & Latin America		
Argentina*	55	UNGASS CR 2003
Barbados*	0	WHO 2002
Belize	70	UNGASS CR 2003
Brazil*	33.6	UNGASS CR 2003
Cuba*	2.5	National target 2002
Dominican Republic	0	WHO 2002
Guatemala	10	UNGASS CR 2003
Guyana	< 1	UNGASS CR 2003
Haiti	0	WHO 2002
Panama	0	WHO 2002
Paraguay	40	WHO 2002
Peru*	14.8	NACP 2002
Trinidad & Tobago	0	WHO 2002
Uruguay*	97.8	NACP 2002
Venezuela*	0	Global report HIV/AIDS 2002
Eastern Europe & Central Asia		
Cyprus*	100	Dept Medical and Health Services
Armenia*	3	UNGASS CR 2003 (1 woman)
Belarus*	87.5	UNGASS CR 2003
Kazakhstan*	4.5	UNGASS CR 2003
Kyrgyzstan*	0	EURO survey 2002
Moldova Republic*	0	NAP 2003
Russian Federation	12	UNGASS CR 2003
Tajikistan*	0	UNGASS CR 2003
Ukraine	49.6	MoH 2002
North Africa & Middle East		
Morocco*	1	WHO 2002
Qatar*	0	MoH HIV registry 2002

* Countries with low prevalence/concentrated epidemics

UNGASS CR 2003 = Programme monitoring data from UNGASS country reports 2003

WHO 2002 = 2002 programme monitoring data through WHO country offices

MoH= Ministry of Health

NACP= National AIDS Control Programme

Annex 7

Percentage of adults with advanced HIV infection receiving antiretroviral treatment

Country	% adults receiving ARV	Source of information
Sub-Saharan Africa		
Angola	< 1	WHO 2002
Benin	2.5	AAI 2002
Botswana	7.9 (2780)	UNGASS CR 2003
Burkina Faso	1.4 (675)	UNGASS CR 2003
Burundi	1.9	AAI 2002
Cameroon	1.5	National Target 2002
Central African Rep	< 1	National Target 2002
Côte d'Ivoire	2.7	UNGASS CR 2003
Democratic Rep. of Congo	0	AAI 2002
Equatorial Guinea	6.8	WHO 2002
Eritrea	< 1	WHO 2002
Ethiopia	< 1	WHO 2002
Gambia	6.3	WHO 2002
Ghana	1.8	WHO 2002
Lesotho	< 1	WHO 2002
Malawi	1.8	UNGASS CR 2003
Mali	2.5	WHO 2003
Mauritius*	100	UNGASS CR 2003
Mozambique	0	WHO 2002
Namibia	0	WHO 2002
Nigeria	1.5 (8,100)	UNGASS CR 2003
Kenya	3	UNGASS CR 2003
Rwanda	< 1 (1,500)	UNGASS CR 2003
Senegal	< 1	AAI 2002
Seychelles*	68.2	UNGASS CR 2003
Sierra Leone	0	WHO 2002
South Africa	0	WHO 2002
Swaziland	1.7 (450)	UNGASS CR 2003
Uganda	6.3 (10,000)	UNGASS CR 2003
United Republic of Tanzania	< 1	UNGASS CR 2003
Zambia	0	WHO 2002
Zimbabwe	0	WHO 2002
South & South-East Asia		
Afghanistan*	0	WHO country office
Bangladesh*	0	WHO 2002
Cambodia	3	NCHADS 2002
India	2	UNGASS CR 2003
Indonesia*	2.7	WHO 2002
Iran*	100	WHO 2002
Myanmar*	< 1	UNGASS CR 2003
Pakistan*	2.2	WHO 2002
Philippines*	3.5	WHO 2002
Sri Lanka*	2	National Target 2002
Singapore*	0	MoH
Thailand	4	NACP 2003
Viet Nam*	1	UNGASS CR 2003
East Asia & Pacific		
China*	5	National Target 2002
Hong Kong*	100	WHO 2002
Papa New Guinea*	0	WHO 2002
Samoa*	100	MoH 2002
Tonga*	0	NACP 2003
Caribbean & Latin America		
Argentina*	91.2 (23253)	UNGASS CR 2003
Bahamas*	< 1	WHO 2002
Belize	7.7 (29)	UNGASS CR 2003
Bolivia*	< 1	WHO 2002
Brazil*	100 (119,500)	UNGASS CR 2003
Dominican Republic	0	National Target 2002
Guatemala	46	UNGASS CR 2003
Guyana	0	WHO 2002
Honduras	< 1	WHO 2002

Country	% adults receiving ARV	Source of information
Jamaica	< 1	AAI 2002
Mexico*	92	UNGASS CR 2003
Nicaragua*	0	WHO 2002
Paraguay*	50 (300)	UNGASS CR 2003
Peru*	19.2	NACP 2002
Trinidad & Tobago	< 1	AAI 2002
Uruguay*	50.5	NACP 2002
Eastern Europe & Central Asia		
Albania*	0	WHO EURO Survey of ARV access 2003
Armenia*	0	WHO EURO Survey of ARV access 2003
Azerbaijan*	0	WHO EURO Survey of ARV access 2003
Belarus*	< 1	UNGASS CR 2003
Bosnia & Herzegovina*	10	WHO EURO Survey of ARV access 2003
Bulgaria*	44.5	WHO EURO Survey of ARV access 2003
Croatia*	98.7	WHO EURO Survey of ARV access 2003
Cyprus*	100	Dept Medical and Health Services
Estonia*	32	WHO EURO Survey of ARV access 2003
Georgia*	8	WHO EURO Survey of ARV access 2003
Hungary*	97	WHO EURO Survey of ARV access 2003
Kazakhstan*	1	UNGASS CR 2003
Kyrgyzstan*	0	EURO survey 2002
Latvia*	51	WHO EURO Survey of ARV access 2003
Lithuania*	55	WHO EURO Survey of ARV access 2003
Macedonia*	20	WHO EURO Survey of ARV access 2003
Moldova Republic*	8.3	WHO 2002
Poland*	92.9	WHO EURO Survey of ARV access 2003
Romania*	64.4	WHO EURO Survey of ARV access 2003
Russian Federation*	83.3	WHO 2002
Serbia & Montenegro*	26.4	WHO EURO Survey of ARV access 2003
Slovakia*	95	WHO EURO Survey of ARV access 2003
Slovenia*	96.3	WHO EURO Survey of ARV access 2003
Tajikistan*	0	UNGASS CR 2003
Ukraine	< 1	MoH and WHO 2002
Uzbekistan*	0	WHO EURO Survey of ARV access 2003
North Africa & Middle East		
Djibouti*	1.8	MoH, WHO 2002
Jordan*	21.3	UNGASS CR 2003
Lebanon*	100	NACP 2003
Morocco*	20.7	UNGASS CR 2003
Qatar*	64.9	HIV registry 2002
Sudan	< 1	WHO 2002
High-income OECD		
Australia*	53.2	Annual Surveillance Report
Austria*	92.6	WHO EURO Survey of ARV access 2003
Belgium*	93.8	WHO EURO Survey of ARV access 2003
Denmark*	90.9	WHO EURO Survey of ARV access 2003
Finland*	94.6	WHO EURO Survey of ARV access 2003
Germany*	94.7	WHO EURO Survey of ARV access 2003
Iceland*	87.5	WHO EURO Survey of ARV access 2003
Italy*	72.7	WHO EURO Survey of ARV access 2003
Luxembourg*	96.9	WHO EURO Survey of ARV access 2003
Malta*	94.3	WHO EURO Survey of ARV access 2003
Netherlands*	96	WHO EURO Survey of ARV access 2003
Norway*	89.6	WHO EURO Survey of ARV access 2003
Spain*	92.3	WHO EURO Survey of ARV access 2003
Sweden*	95	WHO EURO Survey of ARV access 2003
Switzerland*	95	WHO EURO Survey of ARV access 2003
United Kingdom*	92.1	WHO EURO Survey of ARV access 2003

*Countries with low prevalence/concentrated epidemics

AAI= Accelerated Access Initiative

UNGASS CR 2003 = Programme monitoring data from UNGASS country reports 2003

WHO 2002 = 2002 programme monitoring data through WHO country offices

MoH= Ministry of Health

NACP= National AIDS Control Programme

NCHADS= National Centre for HIV/AIDS, Dermatology and STIs

Annex 8

Percentage of young women (aged 15-24) with comprehensive HIV/AIDS knowledge*

Country	Overall (%)	Urban (%)	Rural (%)	Source of information
Sub-Saharan Africa				
Botswana	27.9	25.2	29.8	MICS 2000
Burundi	24	40	21	MICS 2000
Cameroon	16	24	7	MICS 2000
Central African Republic	5.1	1.5	8.7	MICS 2000
Côte d'Ivoire	16	19	6	MICS 2000
Chad	5	2.3	12.2	MICS 2000
Comoros	9.9	9.8	10.4	MICS 2000
Equatorial Guinea	3.8	1.1	6.1	MICS 2000
Gambia	15	20	11	MICS 2000
Guinea Bissau	8	16	2	MICS 2000
Kenya	26	35	22	MICS 2000
Lesotho	18	27	16	MICS 2000
Malawi	34	44	31	DHS 2000
Niger	5	17	2	MICS 2000
Rwanda	23	40	23	DHS 2000
Sao Tome & Principe	11	13	7	MICS 2000
Sierra Leone	16	22	10	MICS 2000
South Africa	20	26	13	DHS 1998
Swaziland	26.9	26.1	28.4	MICS 2000
Togo	20	21	13	MICS 2000
Uganda	28	48	23	DHS 2000
United Republic of Tanzania	26	42	22	DHS 1999
Zambia	25.6	32	20.9	MICS 2000
South & South-East Asia				
Cambodia	37	52	33	DHS 2000
Indonesia	6.8	4.2	10.2	MICS 2000
Viet Nam	25.4	20.8	41.3	MICS 2000
Caribbean & Latin America				
Bolivia	21.6	9.3	29.2	MICS 2000
Cuba	51.8	40.2	56.2	MICS 2000
Dominican Republic	33	33	23	MICS 2000
Guyana	35.6	35.2	36.4	MICS 2000
Haiti	14	24	8	DHS 2000
Suriname	26.5	21	36.8	MICS 2000
Trinidad & Tobago	33	-	-	MICS 2000
Eastern Europe & Central Asia				
Albania	0.2	0.3	0	MICS 2000
Azerbaijan	2.1	0.8	3.2	MICS 2000
Mongolia	32.1	28.1	36.9	MICS 2000
Republic of Moldova	18.9	16.2	22.7	MICS 2000
Uzbekistan	3.4	2.6	5.3	MICS 2000

* Comprehensive HIV knowledge = correct answers regarding two prevention methods and three misconceptions

MICS = UNICEF Multiple Indicator Cluster Survey

DHS = Demographic and Health Survey

Annex 9

Percentage of young women (aged 15-24) with accurate knowledge of HIV-prevention methods

Country	Risk of HIV can be reduced by using condoms (%)	Risk of HIV can be reduced by having sex with one partner (%)	Source of information
Sub-Saharan Africa			
Botswana	76	76	MICS 2000
Burundi	47	71	MICS 2000
Cameroon	46	51	MICS 2000
Central African Republic	20	49	MICS 2000
Chad	21	32	MICS 2000
Comoros	41	42	MICS 2000
Côte d'Ivoire	53	55	MICS 2000
Equatorial Guinea	26	29	MICS 2000
Gambia	51	55	MICS 2000
Guinea Bissau	32	26	MICS 2000
Kenya	53	75	MICS 2000
Lesotho	58	50	MICS 2000
Malawi	66	75	DHS 2000
Niger	30	44	MICS 2000
Rwanda	63	72	DHS 2000
Sao Tome & Principe	32	25	MICS 2000
Sierra Leone	30	32	MICS 2000
South Africa	83	81	DHS 1998
Swaziland	63	61	MICS 2000
Togo	63	74	MICS 2000
Uganda	68	83	DHS 2000
United Republic of Tanzania	62	64	DHS 1999
Zambia	64	78	MICS 2000
South & South-East Asia			
Cambodia	64	64	DHS 2000
Indonesia	23	40	MICS 2000
Viet Nam	60	63	MICS 2000
Caribbean & Latin America			
Bolivia	56	63	MICS 2000
Cuba	89	88	MICS 2000
Dominican Republic	73	87	MICS 2000
Guyana	69	73	MICS 2000
Haiti	46	55	DHS 2000
Suriname	58	58	MICS 2000
Trinidad & Tobago	54	82	MICS 2000
Eastern Europe & Central Asia			
Albania	42	55	MICS 2000
Azerbaijan	11	14	MICS 2000
Mongolia	77	79	MICS 2000
Republic of Moldova	56	63	MICS 2000
Tajikistan	5	6	MICS 2000
Ukraine	57	62	MICS 2000
Uzbekistan	22	32	MICS 2000

MICS = UNICEF Multiple Indicator Cluster Survey
DHS = Demographic and Health Survey

Annex 10

Percentage of young women (aged 15-24) with no misconceptions about HIV/AIDS

Country	Healthy-looking person can have HIV (%)	Cannot get HIV from mosquito bites (%)	Cannot get HIV by supernatural means (%)	Source of information
Sub-Saharan Africa				
Botswana	79	47	70	MICS 2000
Burundi	66	48	68	MICS 2000
Cameroon	54	34	48	MICS 2000
Central African Republic	46	22	27	MICS 2000
Chad	28	13	28	MICS 2000
Comoros	55	27	41	MICS 2000
Côte d'Ivoire	51	38	45	MICS 2000
Equatorial Guinea	46	15	31	MICS 2000
Gambia	53	31	47	MICS 2000
Guinea Bissau	31	27	28	MICS 2000
Kenya	75	55	76	MICS 2000
Lesotho	46	36	56	MICS 2000
Malawi	84	69	80*	DHS 2000
Niger	22	19	34	MICS 2000
Rwanda	64	60	68*	DHS 2000
Sao Tome & Principe	65	37	47	MICS 2000
Sierra Leone	35	29	37	MICS 2000
South Africa	54	45	70*	DHS 1998
Swaziland	81	55	75	MICS 2000
Togo	67	48	53	MICS 2000
Uganda	76	47	67*	DHS 2000
United Republic of Tanzania	65	54	54*	DHS 1999
Zambia	75	63	68	MICS 2000
South & South-East Asia				
Cambodia	62	52	60*	DHS 2000
Indonesia	32	32	47	MICS 2000
Viet Nam	63	44	71	MICS 2000
Caribbean & Latin America				
Bolivia	55	40	63	MICS 2000
Cuba	91	65	91	MICS 2000
Dominican Republic	89	47	87	MICS 2000
Guyana	84	57	77	MICS 2000
Haiti	68	28	18	DHS 2000
Suriname	70	46	57	MICS 2000
Trinidad & Tobago	95	71	87	MICS 2000
Eastern Europe & central Asia				
Albania	40	14	2	MICS 2000
Azerbaijan	35	7	15	MICS 2000
Mongolia	57	58	74	MICS 2000
Republic of Moldova	79	38	72	MICS 2000
Tajikistan	8	4	6	MICS 2000
Ukraine	78	39	61	MICS 2000
Uzbekistan	41	15	22	MICS 2000

* "Cannot be infected by sharing a meal with someone infected" instead of "Cannot get HIV by supernatural means"

MICS = UNICEF Multiple Indicator Cluster Survey

DHS = Demographic and Health Survey

Annex 11

Percentage of young people (aged 15-24) who used a condom the last time they had sex with a non-regular partner

Country	Men (%)	Male urban (%)	Male rural (%)	Female(%)	Female urban (%)	Female rural (%)	Source of information
Sub-Saharan Africa							
Benin	34			19			DHS 2001
Botswana	88			75			MICS 2000
Burkina Faso	55	82	41	41	57	28	DHS 1999
Cameroon	31	38	26	16	23	10	DHS 1998
Congo				12			PSI 1999
Côte d'Ivoire	56	62	49	25	32	15	DHS 1998
Democratic Rep. of Congo				13			MICS 2000
Ethiopia	30	61	20	17	30	6	DHS 2000
Gabon	48			33			DHS 2000
Ghana	33			20			DHS 1998
Guinea	32	44	19	17	23	7	DHS 1999
Kenya	43	46	42	14	20	12	DHS 1998
Malawi	38	51	35	32	48	26	DHS 2000
Mali	30			14			DHS 2001
Nigeria	38			21			DHS 1999
Rwanda	55	72	44	23	32	14	DHS 2000
South Africa				20			DHS 1998
Togo	41	48	36	22	26	16	DHS 1998
Uganda	62	77	55	44	62	36	DHS 2000
United Republic of Tanzania	31	49	23	21	35	12	DHS 1999
Zambia	38			38			ZSBS 2000
Zimbabwe	69	82	60	42	56	29	DHS 1999
South & South-East Asia							
Cambodia				43			DHS 2000
India	51			40			BSS 2001
Nepal	52						DHS 2001
Caribbean & Latin America							
Bolivia	22			8			DHS 1998
Brazil	59			32			DHS 1996
Chile	33			18			DHS 1997
Colombia				29			DHS 2000
Dominican Republic	48			12			DHS 1999
Haiti	30	45	18	19	26	12%	DHS 2000
Jamaica				38			RHS 1997
Mexico	57			57			BSS 2000
Paraguay				79			RHS 1996
Peru				19			DHS 2000

MICS = UNICEF Multiple Indicator Cluster Survey
DHS = Demographic and Health Survey
RHS = Reproductive Health Survey
PSI = Population Services International
BSS = Behavioural Surveillance Surveys
ZSBS = Zambia Sexual Behavioural Survey

Annex 12

Percentage of young people (aged 15-24) in sub-Saharan Africa reporting higher-risk sex* in the last year

Country	Men (%)	Women (%)	Source of information
Sub-Saharan Africa			
Burkina Faso	82	19	DHS 1999
Cameroon	86	41	DHS 1998
Côte d'Ivoire	91	51	DHS 1998
Ethiopia	64	7	DHS 2000
Guinea	92	23	DHS 1999
Kenya	92	39	DHS 1998
Malawi	71	17	DHS 2000
Rwanda	42	10	DHS 2000
Togo	89	51	DHS 1998
Uganda	59	22	DHS 2000
United Republic of Tanzania	87	40	RCHS 1999
Zimbabwe	82	20	DHS 1999

* Respondents who have had sex with a non-marital, non-cohabiting partner in the last 12 months, of all respondents reporting sexual activity in the last 12 months

DHS = Demographic and Health Survey

RCHS = Reproductive and Child Health Survey

Annex 13

Median age at first sex – sub-Saharan Africa

Country	Men	Male urban	Male rural	Women	Female urban	Female rural	Source of information
Sub-Saharan Africa							
Burkina Faso	19.5	18.7	19.8	17.5	18.1	17.3	DHS 1999
Cameroon	17.5	17.4	17.6	16.5	16.6	16.4	DHS 1998
Côte d'Ivoire	17.1	17	17.2	16.5	16.7	16.3	DHS 1998
Ethiopia	22.1	21.9	22.1	19	20.8	18.7	DHS 2000
Ghana	20.5	21.4	20	18.1	19.1	17.6	DHS 1998
Guinea	17.4	16.9	17.7	16.7	17.5	16.4	DHS 1999
Kenya	17.1	17	17.1	17.9	17.4	17.9	DHS 1998
Malawi	16.5	17.8	16.3	17	17	17	DHS 2000
Nigeria	19.4	19.2	19.4	18.1	19	17.6	DHS 1999
Rwanda	20.4	19.3	20.6	20.8	20.4	20.9	DHS 2000
South Africa				17.8	18	17.6	DHS 1998
Togo	18.1	18.4	17.9	16.7	16.9	16.6	DHS 1998
Uganda	18.3	17.3	18.4	17.3	17	17.3	DHS 2000
United Rep. of Tanzania	16.8	16.2	17	17.1	17.2	17.1	DHS 1999
Zimbabwe	19	19.1	19	18.8	19.4	18.5	DHS 1999

DHS = Demographic and Health Survey

Annex 14

Ratio of school attendance – orphans *vs* non-orphans*

Country	Boys	Girls	Combined	Source of information
Sub-Saharan Africa				
Angola			0.9	MICS 2000
Botswana			0.99	MICS 2000
Burundi			0.7	MICS 2000
Cameroon		0.64	0.94	DHS 1998 for combined DHS 2000 for female
Central African Republic			0.91	MICS 2000
Chad			0.96	MICS 2000
Comoros			0.59	MICS 2000
Côte d'Ivoire			0.83	MICS 2000
Democratic Rep. Congo			0.72	MICS 2000
Equatorial Guinea			0.95	MICS 2000
Ethiopia	0.58	0.64	0.6	DHS 2000
Gabon			0.98	DHS 2001
Gambia			0.85	MICS 2000
Ghana			0.93	DHS 1998
Guinea	0.86	1.55	1.13	DHS 1999
Guinea Bissau			1.03	MICS 2000
Kenya	0.79	0.71	0.74	DHS 1998
Lesotho			0.87	MICS 2000
Madagascar			0.65	MICS 2000
Malawi	0.96	0.9	0.93	DHS 2000
Mali			0.72	DHS 2001
Mozambique	0.44	0.5	0.47	DHS 1997
Namibia			0.92	DHS 2001
Niger			1.07	MICS 2000
Nigeria	0.69	1.07	0.87	DHS 1999
Rwanda	0.76	0.86	0.8	MICS 2000
Senegal			0.74	MICS 2000
Sierra Leone			0.71	MICS 2000
Somalia			0.65	MICS 2000
Sudan			0.96	MICS 2000
South Africa	0.95	0.96	0.95	DHS 1998
Swaziland			0.91	MICS 2000
Togo			0.96	MICS 2000
Uganda	0.9	1	0.95	DHS 2000
United Republic of Tanzania	0.66		0.74	DHS 1999
Zambia			0.87	MICS 2000
Zimbabwe	0.89	0.82	0.85	DHS 1999

*Ratio of current school attendance among orphans to that among non-orphans aged 10-14

MICS = UNICEF Multiple Indicator Cluster Survey

DHS = Demographic and Health Survey

Annex 15

HIV prevalence among pregnant women (aged 15–24)

Country	Major urban areas (%)	Outside (%)	All (%)	Source of information
Sub-Saharan Africa				
Angola	2.9		2.9	WHO 2002
Botswana	33.3	31.4	31.8	WHO 2002
Burkina Faso			3.9	UNGASS CR 2003
Côte d'Ivoire	8.8	3.8	7.1	WHO 2002
Central African Republic	13.9	13.4		WHO 2002
Cameroon			11.9	WHO 2002
Congo			11	WHO 2002, Brazzaville & Pointe Noire,15-20 years only
Eritrea	1.3			WHO 2002
Ethiopia	15	12.7		WHO 2002
Ghana	3	2.8	2.9	WHO 2002
Kenya			21.8	WHO 2002
Lesotho	22	16.1	16.1	WHO 2002
Malawi	21	15	17.8	WHO 2002
Mali			0.9	WHO 2002
Mauritius			0.1	UNGASS CR 2003
Namibia			17.9	WHO 2002
Nigeria			6	UNGASS CR 2003
Seychelles			0.6	UNGASS CR 2003
South Africa			24.1	WHO 2002
Swaziland	40.6	35.9	39.4	WHO 2002
Togo			7.6	UNGASS CR 2003
Uganda			8.7	UNGASS CR 2003
United Republic of Tanzania		15		WHO 2002
Zambia			15	WHO 2002
Zimbabwe			18	UNGASS CR 2003
South & South-East Asia				
Cambodia			2.7	WHO 2002
Myanmar	1.7			UNGASS CR 2003
Caribbean & Latin America				
Argentina			0.4	UNGASS CR 2003
Brazil			0.7	UNGASS CR 2003
Guatemala			0.5	UNGASS CR 2003
Peru			0.3	WHO 2002
Suriname			3.8	UNGASS CR 2003
Uruguay	0.2			WHO 2002
Eastern Europe & Central Asia				
Armenia	0	0	0	WHO 2002
Belarus			0.8	WHO 2002
Kazakhstan			0.3	WHO 2002
Kyrgyzstan			0	WHO 2002
Mongolia	0	0	0	UNGASS CR 2003
Republic of Moldova			0.4	WHO 2002
Russian Federation			0.1	WHO 2002
Slovenia	0	0	0	WHO 2002
Ukraine			0.3	WHO 2002
North Africa & Middle East				
Cyprus			0	WHO 2002
Djibouti	2.3			WHO 2002
Morocco			0.2	WHO 2002
Qatar	0			WHO 2002

WHO 2002 = most recent surveillance data 2001/2002 through WHO country offices, as part of UNAIDS/WHO HIV/AIDS surveillance

UNGASS CR 2003 = most recent surveillance data 2001/2002 obtained from UNGASS country report 2003

Annex 16

HIV prevalence among sex workers

Country	% sex workers HIV-infected Major urban areas	Source of information
Sub-Saharan Africa		
Angola	19.4	UNAIDS 2002 (1999 data)
Benin	40.8	UNAIDS 2002 (1999 data)
Côte d'Ivoire	31	Retroci/CDC clinic 2001
Djibouti	27.5	UNAIDS 2002 (1998 data)
Ethiopia	73.7	UNAIDS 2002 (1998 data)
Ghana	50	UNAIDS 2002 (1998 data)
Kenya	27	UNAIDS 2002 (2000 data)
Mali	23.4	NACP 2000
Mauritius	5	NACP 2003
Senegal	7	UNAIDS 2002 (1998 data)
South Africa	50.3	UNAIDS 2002 (2000 data)
United Republic of Tanzania	3.5	UNAIDS 2002 (2000 data)
Zambia	68.7	UNAIDS 2002 (1998 data)
South & South East-Asia		
Bangladesh	0.2	UNAIDS 2002 (2000 data)
Cambodia	28.8	NACP 2002
India	5.3	UNAIDS 2002 (1998 data)
Indonesia	0.2	UNAIDS 2002 (1998 data)
Laos People's Dem. Rep.	0.4	UNGASS CR 2003
Myanmar	38	UNAIDS 2002 (2000 data)
Nepal	36.2	UNAIDS 2002 (1999 data)
Sri Lanka	0	UNAIDS 2002 (1998 data)
Singapore	0.5	UNAIDS 2002 (1998 data)
Thailand	6.7	UNAIDS 2002 (2000 data)
Viet Nam	11	UNAIDS 2002 (2000 data)
East Asia & Pacific		
China	0.3	UNGASS CR 2003
Cook Islands	0	NACP 2002
Hong Kong	0	UNAIDS 2002 (1998 data)
Mongolia	0	NACP 2002
Papua New Guinea	16	UNAIDS 2002 (2000 data)
Philippines	1	NACP 2002
Samoa	0	NACP 2002
Caribbean & Latin America		
Argentina	2.9	UNGASS CR 2003
Brazil	17.8	UNAIDS 2002 (1998 data)
Dominican Republic	3.5	UNAIDS 2002 (1999 data)
Ecuador	1.1	UNAIDS 2002 (2001 data)
Guatemala	4.7	UNAIDS 2002 (1998 data)
Guyana	45	UNAIDS 2002 (2000 data)
Honduras	7.7	UNAIDS 2002 (1999 data)
Mexico	0.3	UNAIDS 2002 (1999 data)
Peru	1.6	UNAIDS 2002 (1998 data)

Country	% sex workers HIV-infected Major urban areas	Source of information
Eastern Europe & Central Asia		
Albania	0.5 to 6	NACP 2002
Belarus	0 to 4	EURO project including sex worker rates in 11 cities 2002
Bosnia & Herzegovina	40	WHO EURO mission report 2001. N unknown
Georgia	1.4	NACP 2000
Hungary	1	UNGASS CR 2003
Latvia	11	UNAIDS 2002 (1998 data)
Russian Federation	1.4 1	EURO project (Moscow) 2002 Report of the Minister, 29/03/03
Slovakia	0.9	NACP 2001
Ukraine	13.2	NACP (1997-2000)
North Africa & Middle East		
Djibouti	27.5	UNAIDS 2002 (1998 data)
Egypt	0	UNAIDS 2002 (1999 data)
Jordan	4.9	NACP 2002
Morocco	0	NACP 2002
Syrian Arab Republic	0	UNAIDS 2002 (1999 data)
Tunisia	0	UNAIDS 2002 (1999 data)
High-income countries		
Australia	0.2	NACP 2002

UNAIDS 2002 = Report on the global HIV/AIDS Epidemic, UNAIDS 2002. Data are from studies in urban areas and figure shown in the table is the median for all sites. Only data from 1997 onwards were selected.

NACP = National AIDS Control Programme within the Ministry of Health

Annex 17

Estimated number of injecting drug users; percentage of injecting drug users who are HIV-infected; and percentage of injecting drug users reached by prevention services

Country	Estimated number of IDUs	HIV prevalence (%)	Coverage (%)
Asia and Pacific			
Bangladesh		4	
China	400,000	7.2	5
Hong Kong		0	
Indonesia	160,000		1.5
Malaysia		16.8	
Myanmar		47.6	
Nepal	20,000	40	22
Pakistan	60,000	0	0.4
Philippines		2	
Singapore		0.2	
Thailand		39.6	
Viet Nam	84,000	41.5	62.7
Latin America			
Argentina		5.8	
Brazil	800,000	0.4	10.5
Eastern Europe and Central Asia			
Belarus	50,000	6.7	1.7
Kazakhstan	250,000	3.3	
Republic of Moldova		1.1	
Romania	30,000		2.2
Russian Federation		3.2	
Ukraine		8.6	
North Africa and Middle East			
Iran	140,000		0.6

Annex 18

Estimated percentage of HIV-infected infants born to HIV-infected mothers

Country	% HIV-infected infants **
Sub-Saharan Africa	
Benin	25
Botswana	20.8
Burkina Faso	25
Chad	25
Democratic Rep. of Congo	25
Ethiopia	25
Kenya	24.9
Malawi	24.9
Mauritius*	12.5
Namibia	24
Niger	25
Nigeria	25
Seychelles*	12.5
Sierra Leone	25
South Africa	25
Uganda	24.4
United Republic of Tanzania	25
South & South-East Asia	
Afghanistan	25
Cambodia	24.7
India	25
Malaysia	25
Myanmar	24.8
Nepal*	24.8
Viet Nam	24.8
East Asia & Pacific	
Guam*	25
Mongolia*	25
Samoa*	25
Caribbean & Latin America	
Argentina*	18.1
Barbados*	25
Belize	16.3
Brazil*	20.8
Cuba*	24.7
Dominican Republic	25
Guatemala	23.8
Guyana	24.9
Haiti	25
Mexico	24
Panama	25
Peru*	23.1
Trinidad & Tobago	25
Uruguay*	12.8
Venezuela*	25
Eastern Europe & Central Asia	
Armenia*	24.6
Belarus*	14.1
Kazakhstan*	24.4
Kyrgyzstan*	25
Republic of Moldova*	25
Russian Federation	23.5
Tajikistan*	25
Ukraine	18.8
North Africa & Middle East	
Morocco*	24.9
Qatar*	25

* Countries with low/concentrated HIV epidemics

** Calculated based on proportion of HIV-infected pregnant women receiving ARV treatment

The Joint United Nations Programme on HIV/AIDS (UNAIDS) brings together eight UN agencies in a common effort to fight the epidemic: the United Nations Children's Fund (UNICEF), the United Nations Development Programme (UNDP), the United Nations Population Fund (UNFPA), the United Nations International Drug Control Programme (UNDCP), the International Labour Organization (ILO), the United Nations Educational, Scientific and Cultural Organization (UNESCO), the World Health Organization (WHO), and the World Bank.

UNAIDS, as a cosponsored programme, unites the responses to the epidemic of its eight cosponsoring organizations and supplements these efforts with special initiatives. Its purpose is to lead and assist an expansion of the international response to HIV/AIDS on all fronts. UNAIDS works with a broad range of partners—governmental and nongovernmental, business, scientific and lay—to share knowledge, skills and best practices across boundaries.

Produced with environment-friendly materials

At the close of the groundbreaking United Nations General Assembly Special Session (UNGASS) on HIV/AIDS in June 2001, 189 Member States adopted the *Declaration of Commitment on HIV/AIDS*. The UNAIDS Secretariat and Cosponsors collaboratively developed a series of global, regional and national indicators to measure the global community's progress in reaching the Declaration's targets. In 2003, surveys were submitted to all 189 Member States, with 103 submitting national reports.

This report, which presents data from the first use of these indicators, represents the most comprehensive assessment to date of the state of global, regional and national responses on the broad range of challenges posed by HIV/AIDS. It is our hope that policy-makers, donors, national authorities, advocates, journalists, and concerned individuals throughout the world will find this report useful, and that the report will help generate even greater commitment towards achieving the targets agreed to at the UN Special Session in 2001.

Joint United Nations Programme on HIV/AIDS

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