

AIDS SCORECARDS

OVERVIEW: UNAIDS REPORT ON
THE GLOBAL AIDS EPIDEMIC | 2010

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ZERO NEW HIV INFECTIONS.

ZERO DISCRIMINATION.

ZERO AIDS-RELATED DEATHS.

FOREWORD



“No child should be born with HIV; no child should be an orphan because of HIV; no child should die due to lack of access to treatment,” urged Ebube Sylvia Taylor, an eleven year old born free of HIV, to world leaders gathered in New York to share progress made towards achieving the Millennium Development Goals by 2015.

We have halted and begun to reverse the epidemic. Fewer people are becoming infected with HIV and fewer people are dying from AIDS.

We must be proud of these successes and the potential of our shared future—breakthroughs in a prevention revolution are at hand with a new microbicide gel holding promise for a whole generation of women who will be able to initiate usage and take control of their ability to stop HIV. Political breakthroughs will be achieved as more countries abolish discriminatory practices led by voices of a new law commission, and Treatment 2.0—a breakthrough that could save an additional 10 million lives.

However we are not yet in a position to say “mission accomplished”.

Growth in investment for the AIDS response flattened for the first time in 2009. Demand is outstripping supply. Stigma, discrimination, and bad laws continue to place roadblocks for people living with HIV and people on the margins.

To fulfill Ebube’s hope, we must break the trajectory of the AIDS epidemic by redoubling our efforts to ensure countries meet their goals towards universal access to HIV prevention, treatment, care and support. We must leverage the growing integration of AIDS with maternal and child health and all of our Millennium Development Goals.

We know that there are solutions. We know that there is political and societal will to bring change. The real challenge is following through. This new fourth decade of the epidemic should be one of moving towards efficient, focused and scaled-up programmes to accelerate progress for Results. Results. Results.

A handwritten signature in black ink, which appears to read 'Michel Sidibé'.

Michel Sidibé
UNAIDS Executive Director
Under Secretary-General of the United Nations

INTRODUCTION



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On the cusp of the fourth decade of the AIDS epidemic, the world has turned the corner—it has halted and begun to reverse the spread of HIV (Millennium Development Goal 6.A). The question remains how quickly the response can chart a new course towards zero new infections, zero discrimination and zero AIDS-related deaths through universal access to effective HIV prevention, treatment, care and support.

Since 1999, the year in which it is thought that the epidemic peaked, globally, the number of new infections has fallen by 19% (Figure 1.1). Of the estimated 15 million people living with HIV in low- and middle-income countries who need treatment today, 5.2 million have access—translating into fewer AIDS-related deaths (Figure 1.2). For the estimated 33.3 million people living with HIV after nearly 30 years into a very complex epidemic, the gains are real but still fragile. Future progress will depend heavily on the joint efforts of everyone involved in the HIV response (Table 1.1).

At a time of financial constraint, good investments are more important than ever. The evidence supporting increased investment in the HIV response has never been clearer or more compelling. New data from 182 countries, along with extensive input from civil society and other sources, clearly show that steady progress is being made towards achieving universal access to HIV prevention, treatment, care and support. HIV prevention is working. Treatment is working. Social welfare programmes are reaching orphans and vulnerable children.

Increasing evidence also definitively demonstrates that investments in the HIV response can lead to clear reductions in discrimination and stigma, help people in accessing information and services to reduce their risk of HIV infection, and deliver the treatment, care, and support that will extend and improve the lives of people living with HIV.

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Table 1.1

Regional HIV and AIDS statistics, 2009 and 2001

Regional figures on adults and children newly infected and living with HIV and AIDS-related deaths

Source: UNAIDS.

		Adults and children living with HIV	Adults and children newly infected with HIV	% Adult prevalence (15–49 years)	AIDS-related deaths among adults and children
SUB-SAHARAN AFRICA	2009	22.5 million [20.9–24.2 million]	1.8 million [1.6–2.0 million]	5.0 [4.7–5.2]	1.3 million [1.1–1.5 million]
	2001	20.3 million [18.9–21.7 million]	2.2 million [1.9–2.4 million]	5.9 [5.6–6.1]	1.4 million [1.2–1.6 million]
MIDDLE EAST AND NORTH AFRICA	2009	460 000 [400 000–530 000]	75 000 [61 000–92 000]	0.2 [0.2–0.3]	24 000 [20 000–27 000]
	2001	180 000 [150 000–210 000]	36 000 [32 000–42 000]	0.1 [0.1–0.1]	8300 [6300–11 000]
SOUTH AND SOUTH-EAST ASIA	2009	4.1 million [3.7–4.6 million]	270 000 [240 000–320 000]	0.3 [0.3–0.3]	260 000 [230 000–300 000]
	2001	3.8 million [3.5–4.2 million]	380 000 [350 000–430 000]	0.4 [0.3–0.4]	230 000 [210 000–280 000]
EAST ASIA	2009	770 000 [560 000–1.0 million]	82 000 [48 000–140 000]	0.1 [0.1–0.1]	36 000 [25 000–50 000]
	2001	350 000 [250 000–480 000]	64 000 [47 000–88 000]	<0.1 [<0.1–<0.1]	15 000 [9400–28 000]
OCEANIA	2009	57 000 [50 000–64 000]	4500 [3400–6000]	0.3 [0.2–0.3]	1400 [<1000–2400]
	2001	29 000 [23 000–35 000]	4700 [3800–5600]	0.2 [0.1–0.2]	<1000 [<500–1100]
CENTRAL AND SOUTH AMERICA	2009	1.4 million [1.2–1.6 million]	92 000 [70 000–120 000]	0.5 [0.4–0.6]	58 000 [43 000–70 000]
	2001	1.1 million [1.0–1.3 million]	99 000 [85 000–120 000]	0.5 [0.4–0.5]	53 000 [44 000–65 000]

		Adults and children living with HIV	Adults and children newly infected with HIV	% Adult prevalence (15–49 years)	AIDS-related deaths among adults and children
CARIBBEAN	2009	240 000 [220 000–270 000]	17 000 [13 000–21 000]	1.0 [0.9–1.1]	12 000 [8500–15 000]
	2001	240 000 [210 000–270 000]	20 000 [17 000–23 000]	1.1 [1.0–1.2]	19 000 [16 000–23 000]
EASTERN EUROPE AND CENTRAL ASIA	2009	1.4 million [1.3–1.6 million]	130 000 [110 000–160 000]	0.8 [0.7–0.9]	76 000 [60 000–95 000]
	2001	760 000 [670 000–890 000]	240 000 [210 000–300 000]	0.4 [0.4–0.5]	18 000 [14 000–23 000]
WESTERN AND CENTRAL EUROPE	2009	820 000 [720 000–910 000]	31 000 [23 000–40 000]	0.2 [0.2–0.2]	8500 [6800–19 000]
	2001	630 000 [570 000–700 000]	31 000 [27 000–35 000]	0.2 [0.2–0.2]	7300 [5700–11 000]
NORTH AMERICA	2009	1.5 million [1.2–2.0 million]	70 000 [44 000–130 000]	0.5 [0.4–0.7]	26 000 [22 000–44 000]
	2001	1.2 million [960 000–1.4 million]	66 000 [54 000–81 000]	0.4 [0.4–0.5]	30 000 [26 000–35 000]
TOTAL	2009	33.3 million [31.4–35.3 million]	2.6 million [2.3–2.8 million]	0.8 [0.7–0.8]	1.8 million [1.6–2.1 million]
	2001	28.6 million [27.1–30.3 million]	3.1 million [2.9–3.4 million]	0.8 [0.7–0.8]	1.8 million [1.6–2.0 million]

This report revises the estimate of the number of people living with HIV in 2008 of 33.4 million [31.1 million–35.8 million] published in *AIDS epidemic update: November 2009*, to 32.8 million [30.9 million–34.7 million], which is within the uncertainty range of the previous estimate. This revision is based on additional data becoming available for many countries, including data from population-based surveys such as in Mozambique.

AIDS epidemic update: November 2009 included Mexico in Latin America. This report includes Mexico in North America and categorizes the rest of Latin America as Central and South America. This report presents trend analysis based on the new definition of these regions.

» **More than 5 million people are now receiving HIV treatment**

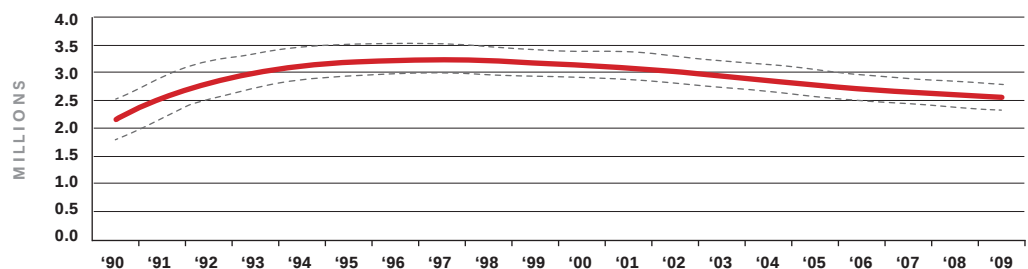
In 2009 alone, 1.2 million people received HIV antiretroviral therapy for the first time—an increase in the number of people receiving treatment of 30% in a single year. Overall, the number of people receiving therapy has grown 13-fold, to 5.2 million people in low- and middle-income countries, since 2004. Expanding access to treatment has contributed to a 19% decline in deaths among people living with HIV between 2004 and 2009 (Figure 1.3). This success is just the beginning: 10 million people living with HIV who are eligible for treatment under the new WHO guidelines are still in need.

Efforts are now underway for Treatment 2.0, a new approach to simplify the way HIV treatment is currently provided and to scale up access to life-saving medicines. Using a combination of efforts, this new approach could bring down treatment costs, make treatment regimens simpler and smarter, reduce the burden on health systems, and improve the quality of life for people living with HIV and their families. Modelling suggests that, compared with current treatment approaches, Treatment 2.0 could avert an additional 10 million deaths by 2025.

In addition, the new platform could reduce the number of people newly infected with HIV by up to 1 million annually if countries provide antiretroviral therapy to all people in need, following revised WHO treatment guidelines.

Figure 1.1
Number of people newly infected with HIV

Source: UNAIDS.



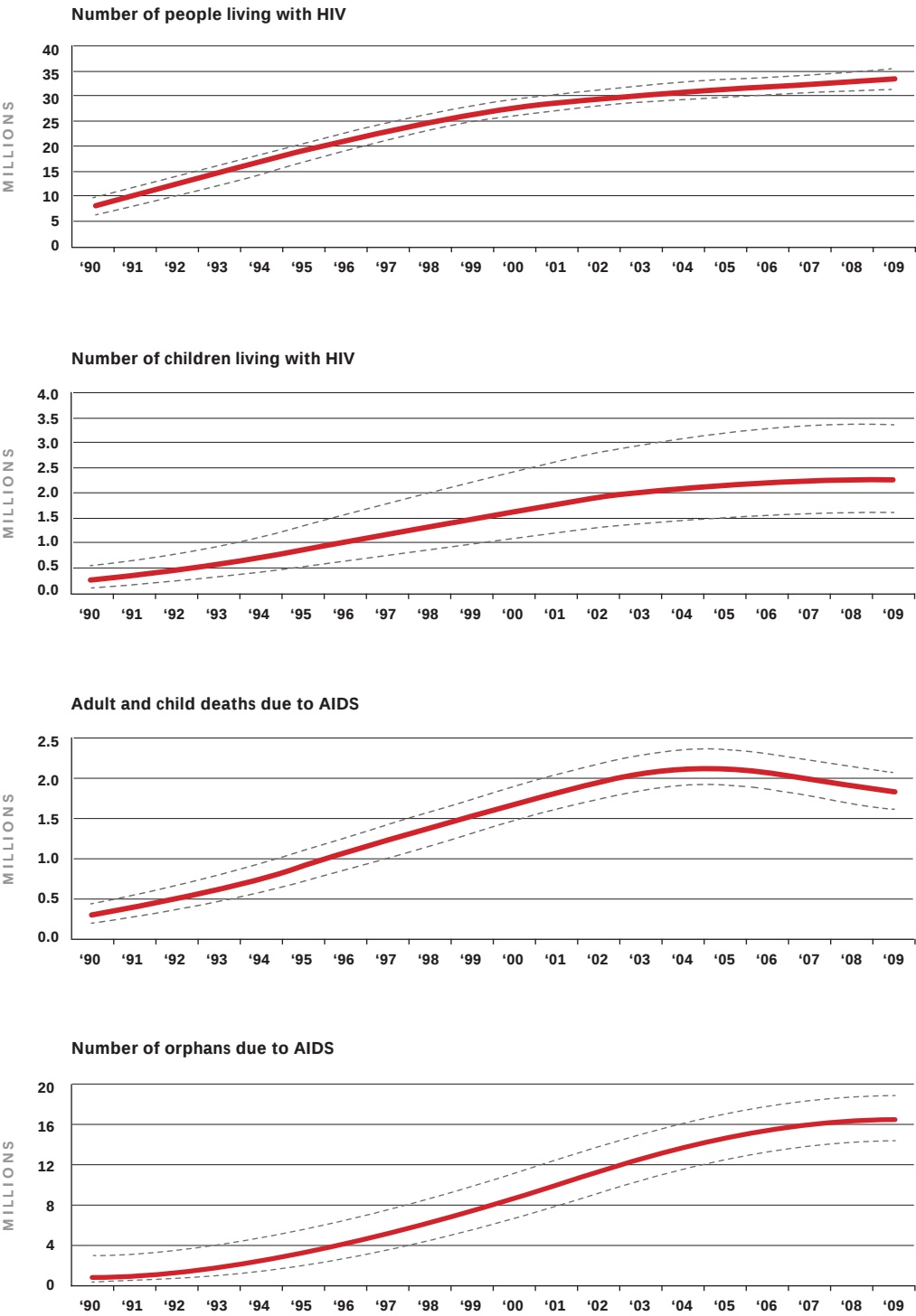
Note about Figures:

Dotted lines in figures represent ranges, solid lines represent the best estimate.

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Figure 1.2
Global HIV trends, 1990 to 2009

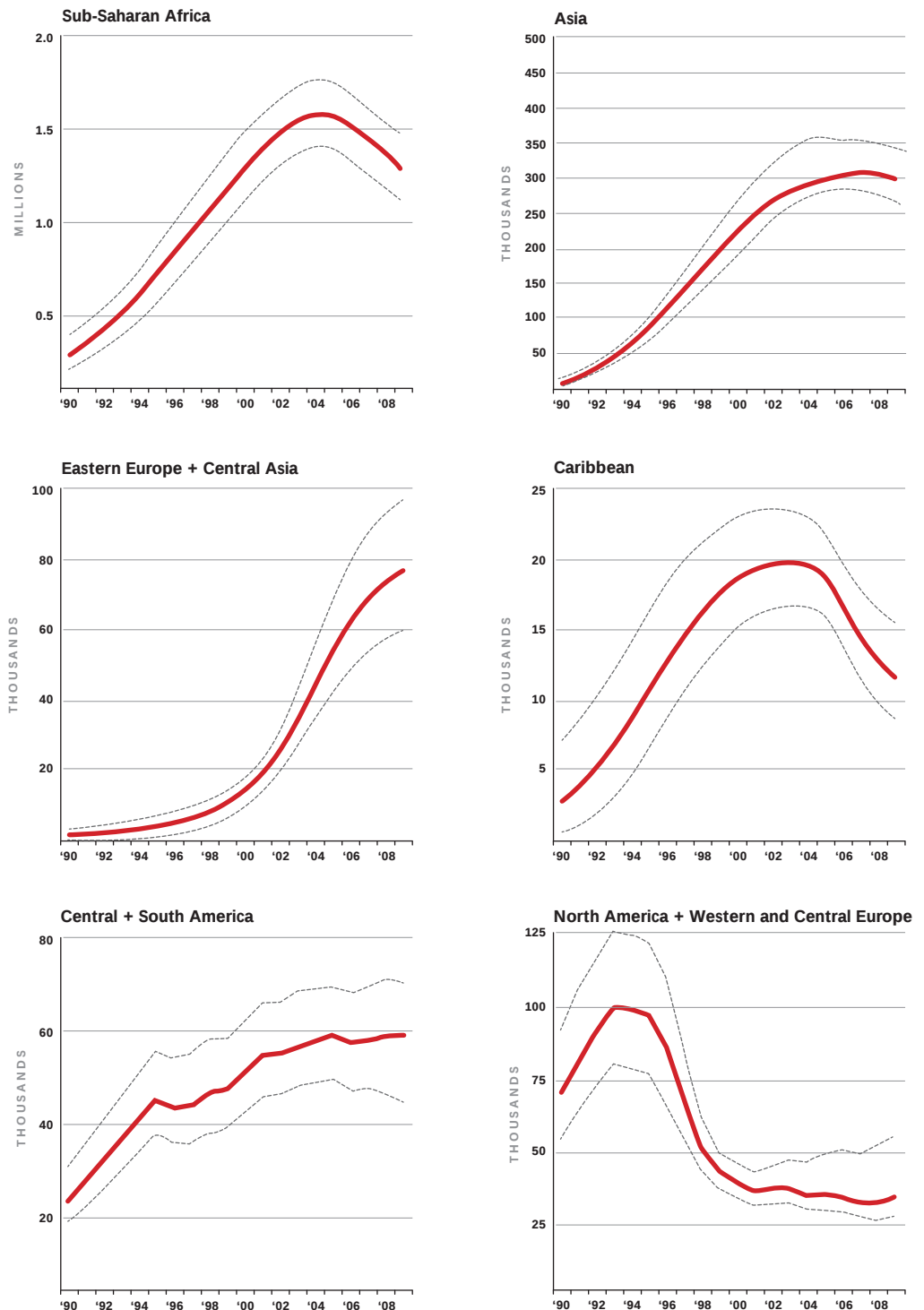
Source: UNAIDS.



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Figure 1.3
Annual AIDS-related deaths by region, 1990 to 2009

Source: UNAIDS.



HIV prevention works—new HIV infections are declining in many countries most affected by the HIV epidemic

In 33 countries, HIV incidence has fallen by more than 25% between 2001 and 2009. Twenty-two of these countries are in sub-Saharan Africa. The biggest epidemics in sub-Saharan Africa—Ethiopia, Nigeria, South Africa, Zambia, and Zimbabwe—have either stabilized or are showing signs of decline.

Several regions and countries do not fit the overall trend. In seven countries, five of them in Eastern Europe and Central Asia, HIV incidence increased by more than 25% between 2001 and 2009.

These figures demonstrate that positive behaviour change can alter the course of the epidemic—while stigma and discrimination, lack of access to services and bad laws can make epidemics worse. In both cases, the effects are often profound.

Among young people in 15 of the most severely affected countries, HIV prevalence has fallen by more than 25% as these young people have adopted safer sexual practices. Similar to treatment access, the room for continued improvement on this success is great. Young people's knowledge about HIV is increasing but needs to grow further.

Virtual elimination of mother-to-child transmission of HIV is possible

In 2009, an estimated 370 000 children [220 000–520 000] contracted HIV during the perinatal and breastfeeding period, down from 500 000 [320 000–670 000] in 2001.

Although this is a significant reduction, HIV continues to weigh heavily on maternal and child mortality in some countries. But in South Africa, which achieved almost 90% coverage of treatment to prevent mother-to-child transmission of HIV, transmission to infants has been drastically reduced. In many communities, countries and regions of the world, however, access to services to halt mother-to-child transmission needs to be scaled up.

In 2009, UNAIDS called for the virtual elimination of mother-to-child transmission of HIV by 2015 (Figure 1.4). In the 10 most severely affected countries, this is a realistic aim and can be achieved with significantly increased action to implement proven strategies to eliminate HIV transmission to young people.

25%

HIV incidence has fallen more than 25% between 2001 and 2009 in 33 countries.

Women and girls need support

Slightly more than half of all people living with HIV are women and girls. In sub-Saharan Africa, more women than men are living with HIV, and young women aged 15–24 years are as much as eight times more likely than men to be HIV positive. Protecting women and girls from HIV means protecting against gender-based violence and promoting economic independence from older men.

Human rights are increasingly a part of national strategies

Human rights are no longer considered peripheral to the AIDS response. Today, the vast majority of countries (89%) explicitly acknowledge or address human rights in their national AIDS strategies, with 92% of countries reporting that they have programmes in place to reduce HIV-related stigma and discrimination.

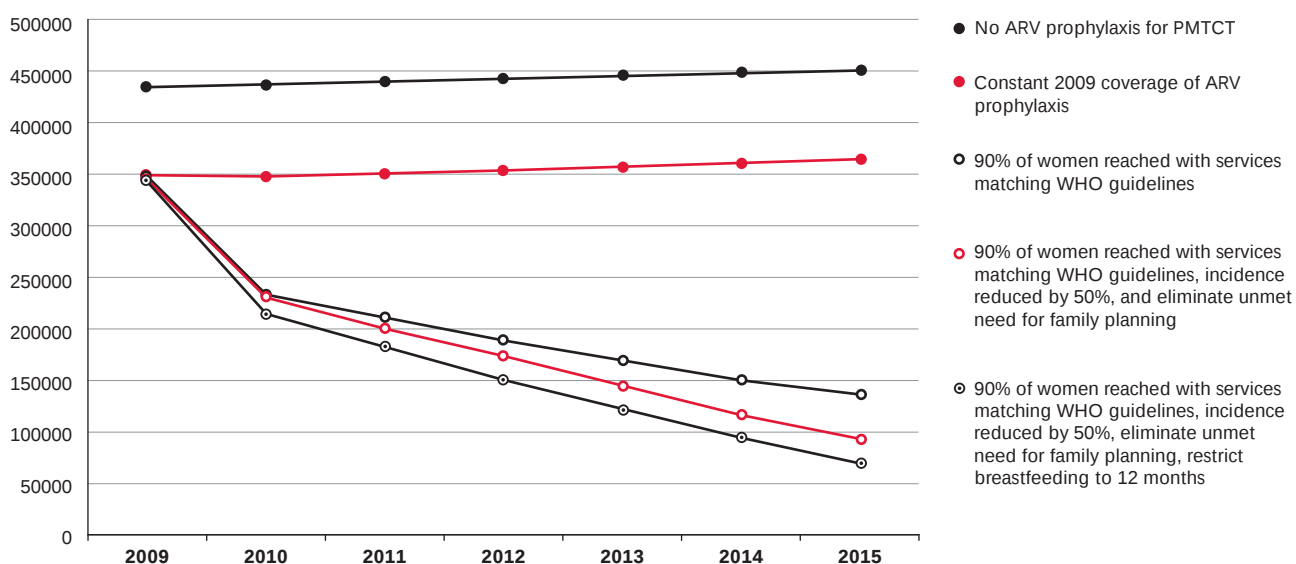
At the same time, however, criminalization of people living with HIV still presents significant challenges to the AIDS response. More than 80 countries across the world have laws against same-sex behaviour, and the free travel of people living with HIV is restricted in 51 countries, territories and areas. Such laws are not only discriminatory and unjust—they also drive HIV underground and inhibit efforts to expand access to life-saving HIV prevention, treatment, care and support.

Figure 1.4

The virtual elimination of mother-to-child transmission of HIV is possible

Estimated New HIV infections among children 0-14:
Different scenarios for 25 countries

Source: Mahy M, Stover J, Kiragu K, et al. What will it take to achieve virtual elimination of mother-to-child transmission of HIV? An assessment of current progress and future needs. *Sex Trans Infect (Suppl)* 2010.



Financing the response is a shared responsibility

Increasingly, countries with heavy HIV burdens are assuming their responsibilities to resource the response to the degree that their means permit. Domestic expenditure is the largest source of HIV financing globally today, accounting for 52% of resources for the HIV response in low- and middle-income countries. Improving financing for the global response will require ongoing efforts to mobilize domestic resources among countries that appear to be under-investing in the HIV response, increasing the efficient use of funds for HIV and related other health and development programmes, and increasing external aid in a global environment of constrained resources.

A fragile progress

Despite extensive progress against a number of indicators on the global scale, many countries will fail to achieve Millennium Development Goal 6: halting and reversing the spread of HIV (Figure 1.5 and Figure 1.6).

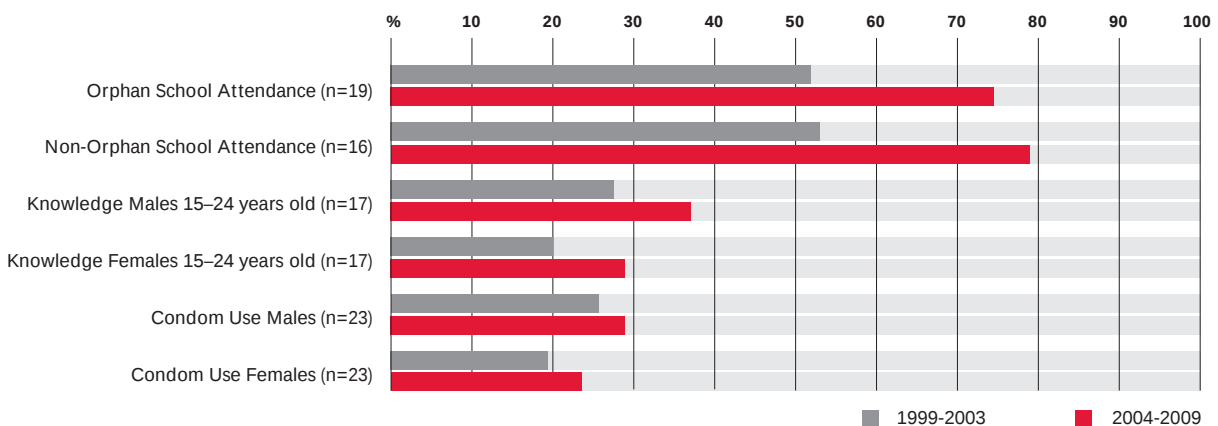
Having more than five million people receiving treatment is a major public health achievement—but still represents only 36% of the people who need HIV therapy now, according to WHO guidelines issued in early 2010. Reaching the two thirds of people who need treatment but are not yet receiving it and financing this expansion in access to HIV therapy will require a continued and expanded global commitment to providing quality HIV care for all.

Figure 1.5

Millennium Development Goal 6 indicators

Population-adjusted averages for indicators for Millennium Development Goal target 6.A (halt and begin to reverse the spread of HIV/AIDS), 1999–2003 and 2004–2009.

Source: DHS and UN Population Statistics.



Knowledge of the epidemic and how to prevent HIV infection has increased among young people aged 15–24 years—people frequently at the highest risk for infection. Six countries have achieved greater than 80% condom use at last higher-risk sex among males, and two countries have achieved this high level of condom use among females (see the HIV prevention scorecard).

Young people still lack knowledge and, importantly, often lack the tools they need to practice HIV risk-reduction strategies, however. Many people still lack ready access to condoms and lubrication, and people who inject drugs also lack sufficient access to sterile needles.

Figure 1.6

Young people and sexual risk

People aged 15–25 years who had sex before age 15 years and who had multiple partners in the past 12 months.

Source: DHS and UN Population Statistics.

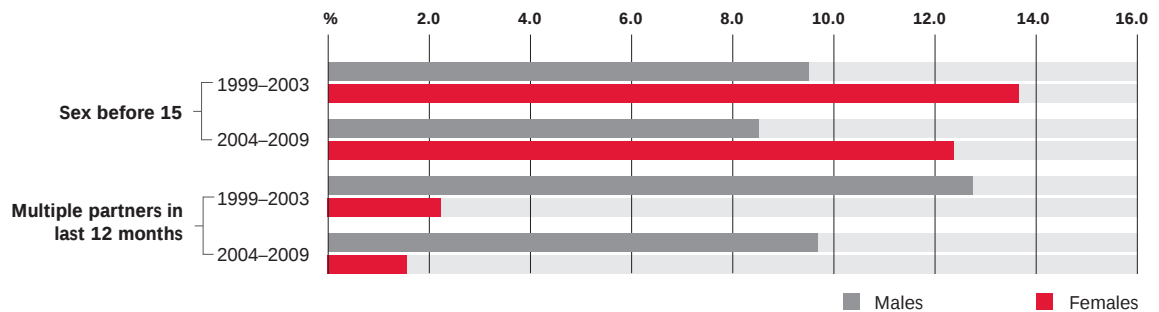
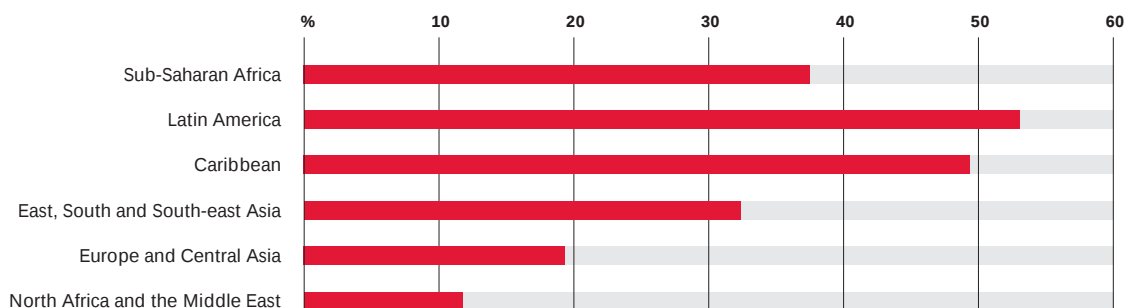


Figure 1.7

Treatment coverage in low- and middle-income countries

Population-adjusted averages for treatment coverage in low- and middle-income countries by geographical region in 2009 based on 2010 WHO guidelines: Millennium Development Goal target 6.B (achieve, by 2010, universal access to treatment for HIV/AIDS for all those who need it). The regional figure for North America is not shown because of lack of data.

Source: WHO Towards Universal Access 2010.



A new vision

Fulfilling the UNAIDS vision of zero new infections will require a hard look at the societal structures, beliefs and value systems that present obstacles to effective HIV prevention efforts. Poverty, gender inequity, inequity in health and the education system, discrimination against marginalized people, and unequal resource pathways all affect—and often slow—the HIV response.

In a world that has had to learn to live with an evolving and seemingly unstoppable epidemic over the course of three decades, UNAIDS’ vision of zero new infections, zero discrimination and zero AIDS-related deaths poses a challenge. But it is not a hopeless challenge. The vision of eliminating the toll that HIV imposes on human life can be made real using the knowledge and resources available today. Planners, programme administrators and implementers must make a sustained and dedicated effort to use the best social and scientific knowledge available. Strengthened programming using the latest knowledge and best practices to deliver effective prevention, treatment and care services to people in need, or at risk, is highly effective.

Building social coalitions to reduce vulnerability to HIV infection supports individuals and strengthens communities. Safeguarding the health of mothers and infants and optimizing infant feeding provides a strong basis for the growth of new generations. Investing in health care and social support systems, working to eliminate violence against women and girls and promote gender equality and working to end stigma and discrimination against people living with HIV and members of other marginalized groups help to provide social environments that are effective against the spread of HIV and promote more general mental and physical well-being. And in providing HIV-specific services with an awareness of other health and social issues and forging appropriate linkages, the response to HIV can make an important contribution to global health.

The Millennium Development Goals are intertwined. Without achieving substantive progress towards the HIV-specific Goal 6, few other Goals are likely to be reached; likewise, without integration and significant progress towards most other Goals being made, Goal 6 will probably not be achieved.

Stopping infections, saving lives and improving the quality of life of people living with HIV have always been at the heart of the global AIDS response. The successes and continuing challenges described in this report should serve as catalysts for continued action. ■

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AIDS SCORECARDS

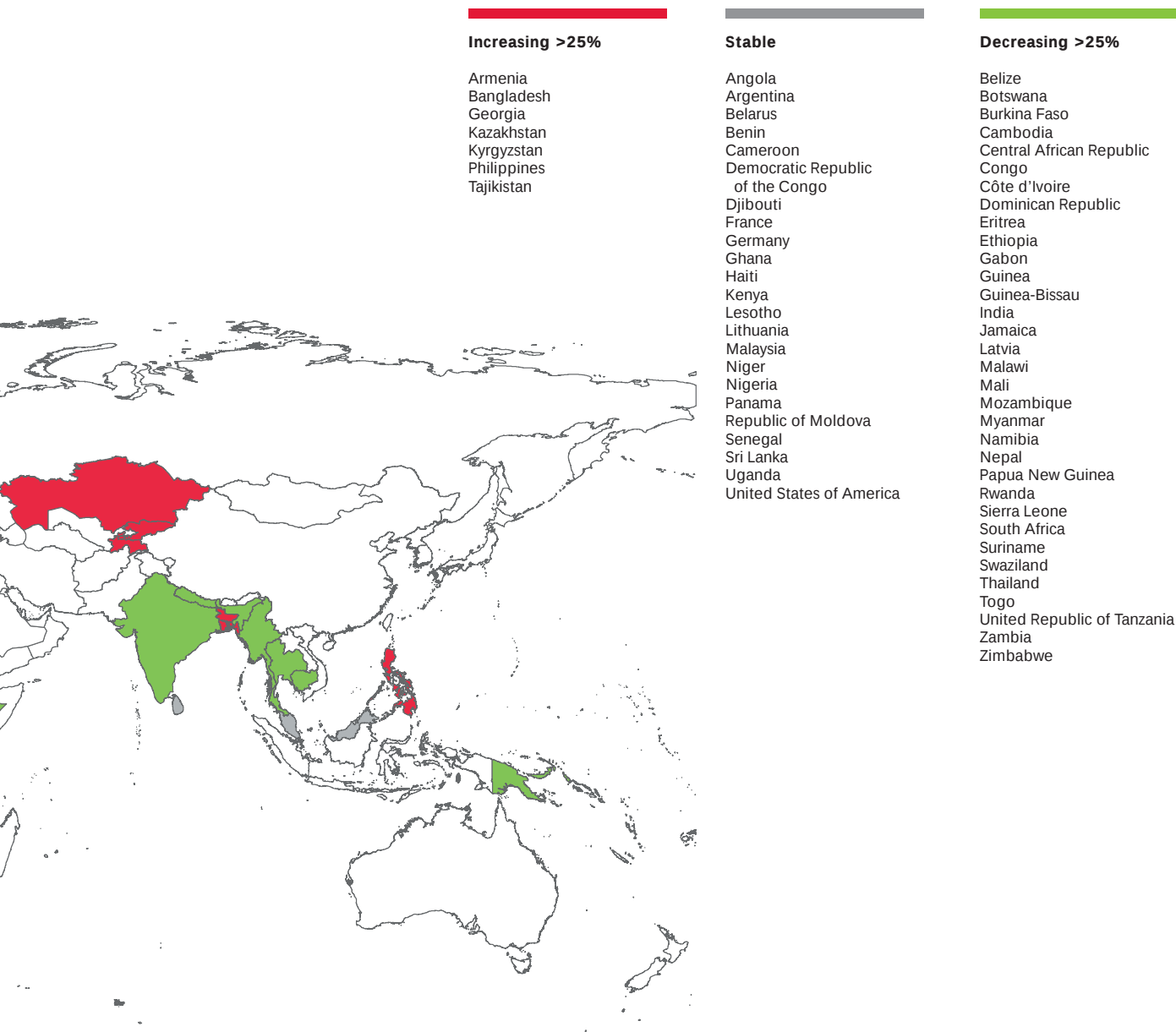
AIDS scorecards provide a quick overview of the progress made by United Nations Member States in the global AIDS response. They provide a snapshot of achievements, failures and obstacles in achieving universal access to HIV prevention, treatment, care and support.

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SCORECARD: INCIDENCE

Changes in the incidence rate of HIV infection, 2001 to 2009, selected countries





In the absence of a reliable diagnostic test that can directly measure the level of new HIV infections in a population, estimates of HIV incidence have been produced through modeling. The map includes 60 countries for which reliable estimates of new HIV infections over time were available from the 2010 round of country-specific estimation using the EPP/Spectrum tools, and 3 countries for which peer-reviewed publications with incidence trends were available. The EPP/Spectrum methods estimate HIV incidence trends from HIV prevalence over time combined with the changing level of antiretroviral therapy. The criteria for including countries in this analysis were as follows. EPP files were available and trends in EPP were not derived from workbook prevalence estimates; prevalence data were available up to at least 2007; there were at least four time points between 2001 and 2009 for which prevalence data were available for concentrated epidemics and at least three data points in the same period for generalized epidemics; for the majority of epidemic curves for a given country, EPP did not produce an artificial increase in HIV prevalence in recent years due to scarcity of prevalence data points; data were representative of the country; the EPP/Spectrum-derived incidence trend was not in conflict with the trend in case reports of new HIV diagnoses; and the EPP/Spectrum-derived incidence trend was not in conflict with modelled incidence trends derived from age-specific prevalence in national survey results. For some countries with complex epidemics including multiple populations groups with different risk behaviours as well as major geographic differences, such as Brazil, China and the Russian Federation, this type of assessment is highly complex and it could not be concluded in the 2010 estimation round. UNAIDS will continue to work with countries and partners to improve the quality of available information and modeling methodologies to include HIV incidence data for additional countries in future reports.

HIV PREVENTION



KEY FINDINGS

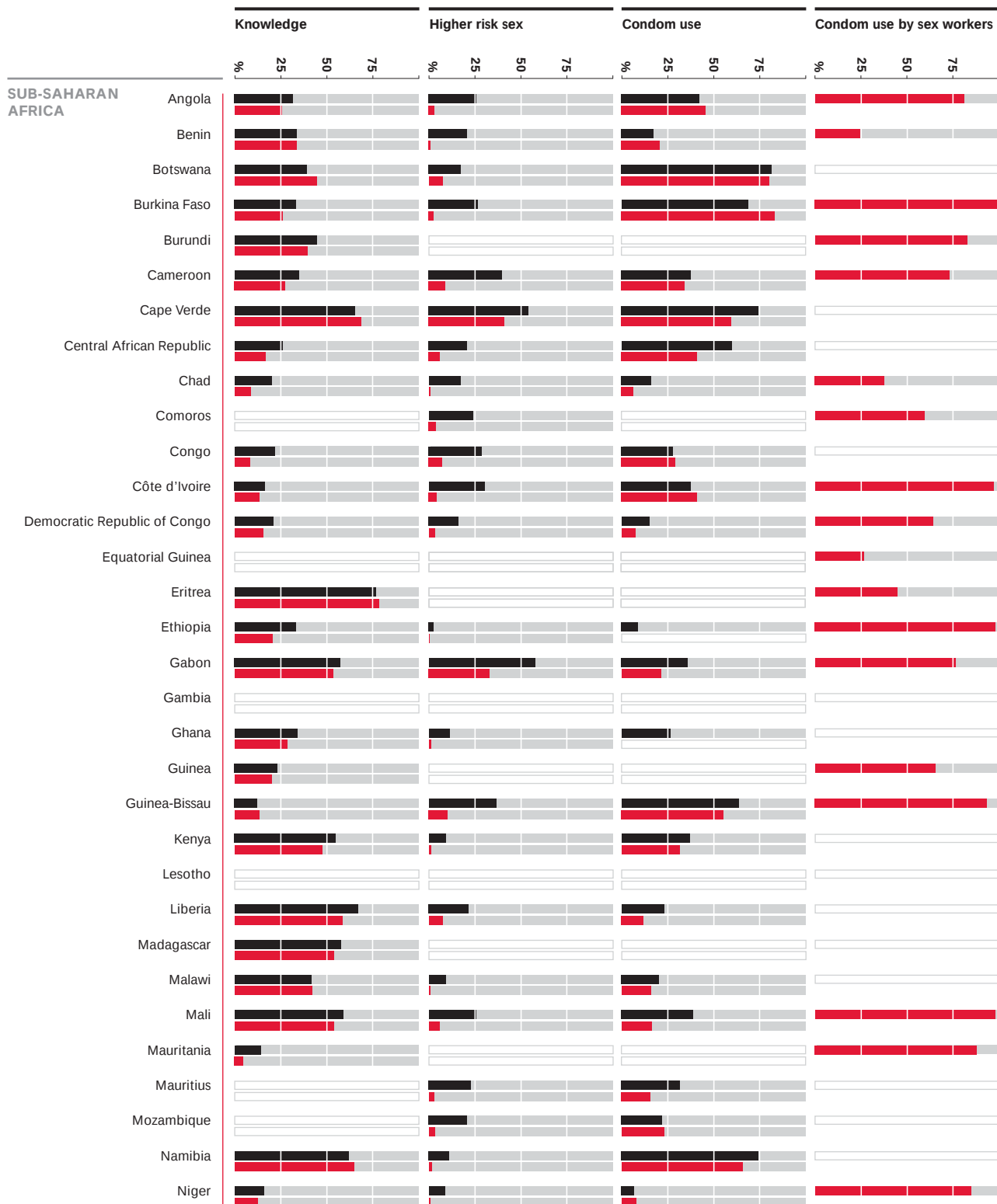
- The global incidence of HIV infection declined by 19% between 1999 and 2009; the decline exceeded 25% in 33 countries, including 22 countries in sub-Saharan Africa.
 - In 2009, 370 000 [230 000–510 000] children were infected with HIV through mother-to-child transmission. This is a drop of 24% from five years earlier. However, rapid expansion of delivery of effective advances in preventing mother-to-child transmission is being held back by inadequate access to antenatal and postnatal services.
 - HIV prevention investments are about 22% of all spending in 106 low- and middle-income countries.
 - Globally, comprehensive and correct knowledge about HIV among both young men and young women has increased slightly since 2008—but at only 34%, the number of young people with this comprehensive knowledge is barely one third of the UNGASS target of 95%.
 - Trend analysis shows a general decline in the percentage of people who have had more than one sexual partner in the past year in sub-Saharan Africa.
 - Condom availability in places of need is increasing significantly, with 25.8 million female condoms provided through international and nongovernmental funding sources in 2009. Condom distribution increased by 10 million between 2008 and 2009.
 - Recent promising results of a tenofovir-based gel have raised hopes that an additional effective female-initiated prevention option may soon become viable.
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ACTION ITEMS

- HIV prevention programmes must be scaled up rapidly.
- Investments in HIV prevention programmes are insufficient and should increase. National programmes should ensure that investments are given priority according to epidemic patterns to reach the populations most in need.
- HIV prevention programmes must include a combination of behavioural, biomedical, and structural responses, and these activities should operate in synergy.
- HIV prevention programmes should reach men who have sex with men, sex workers and their clients, transgender people, and people who inject drugs. Behaviour change and condom promotion efforts must work in tandem.
- The virtual elimination of mother-to-child transmission of HIV is possible. Current advances in stopping new infections among children must be accelerated by integrating services in antenatal care settings.
- New HIV prevention methods such as male circumcision must be scaled up in countries with generalized epidemics.
- The results from the CAPRISA microbicide gel trial hold promise for a woman-initiated and controlled HIV prevention option. The international community must fully support the next steps to confirm the trial results at the earliest.

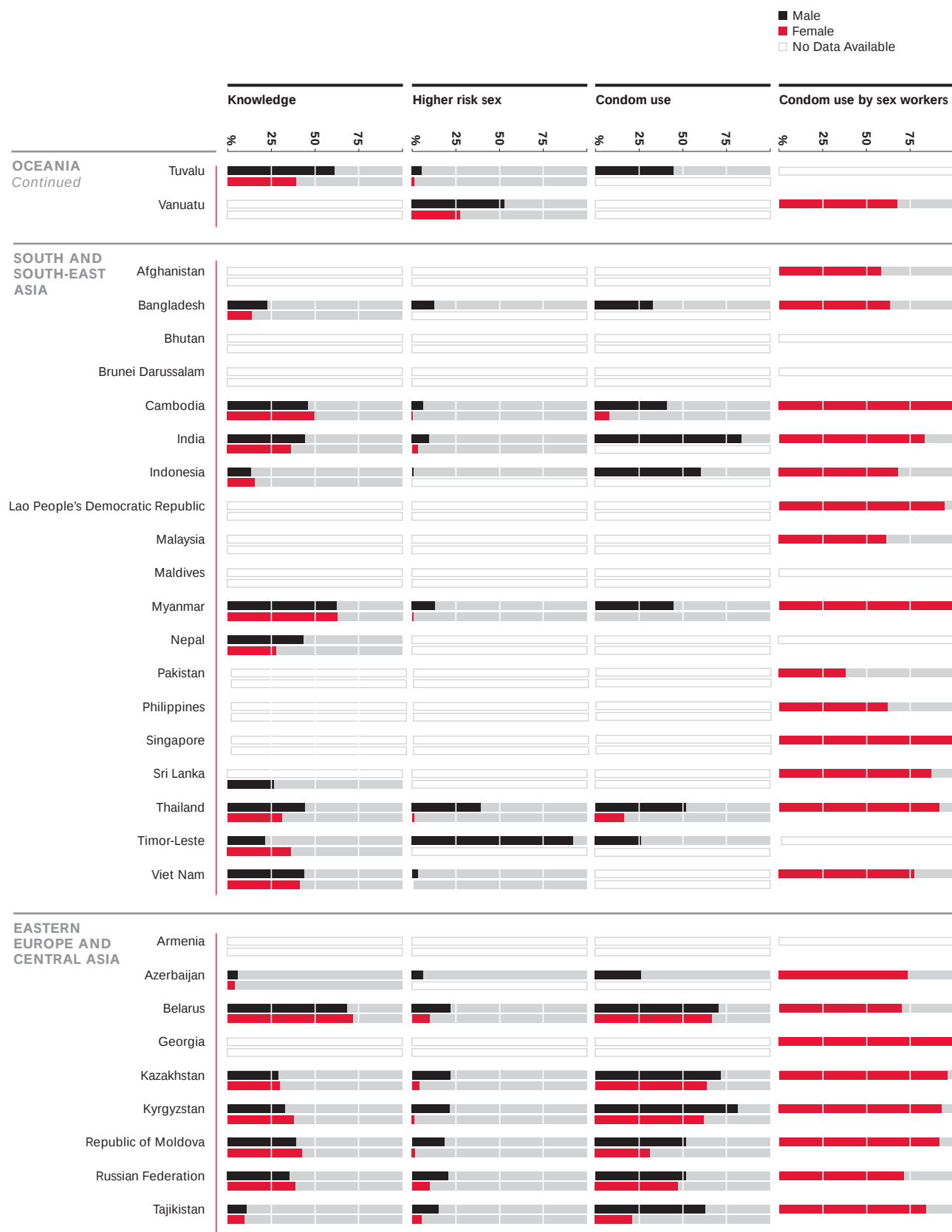
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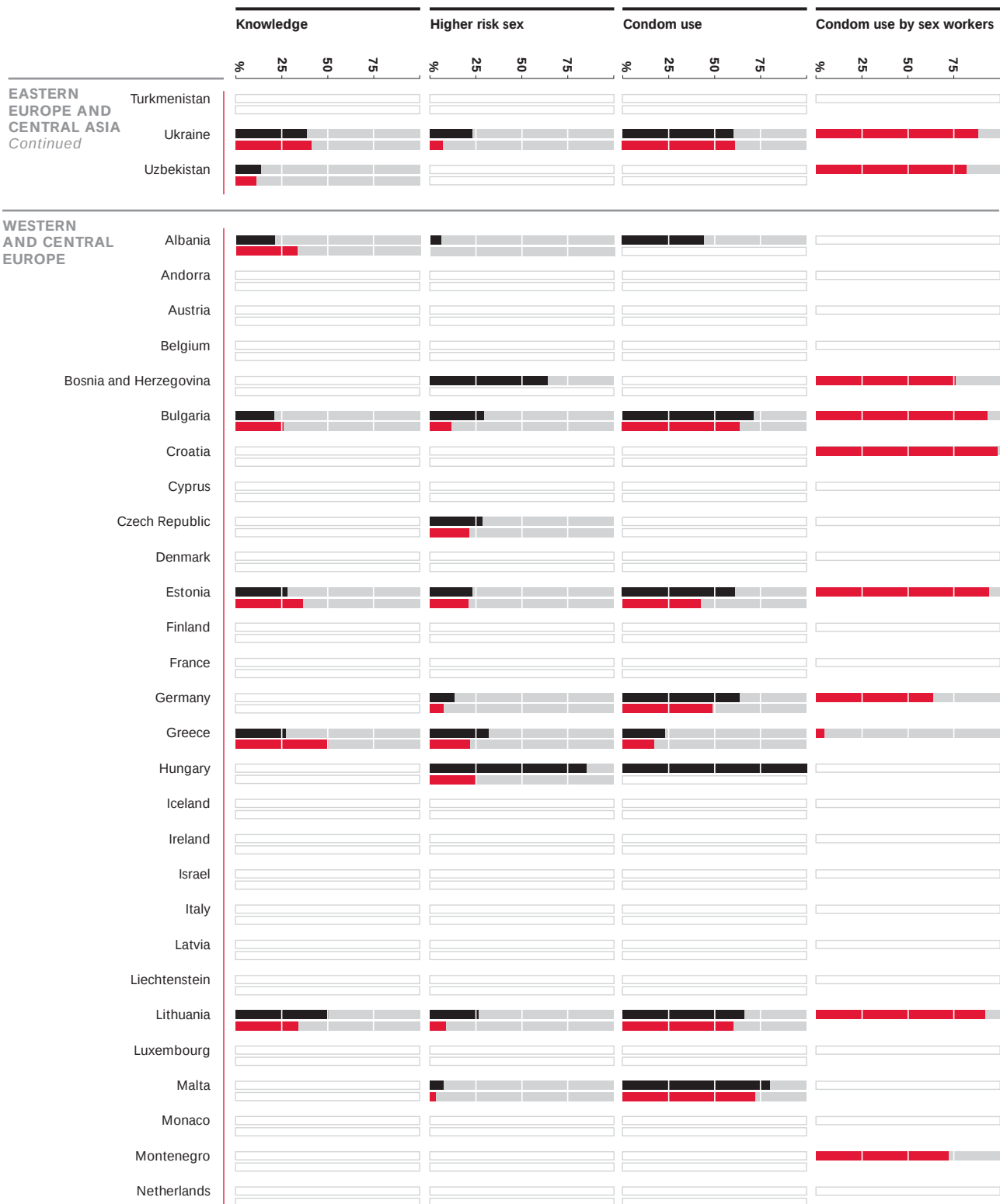
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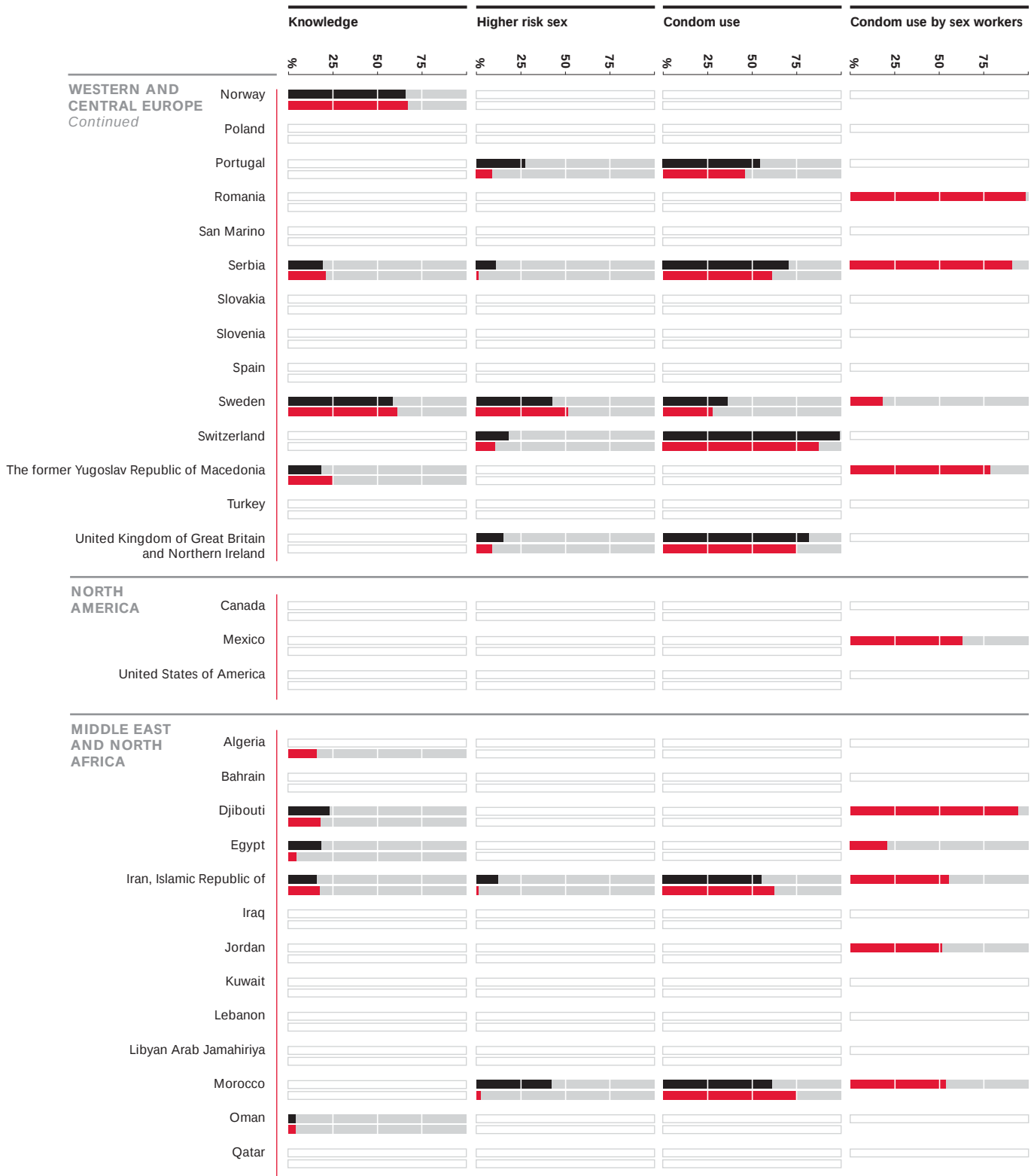
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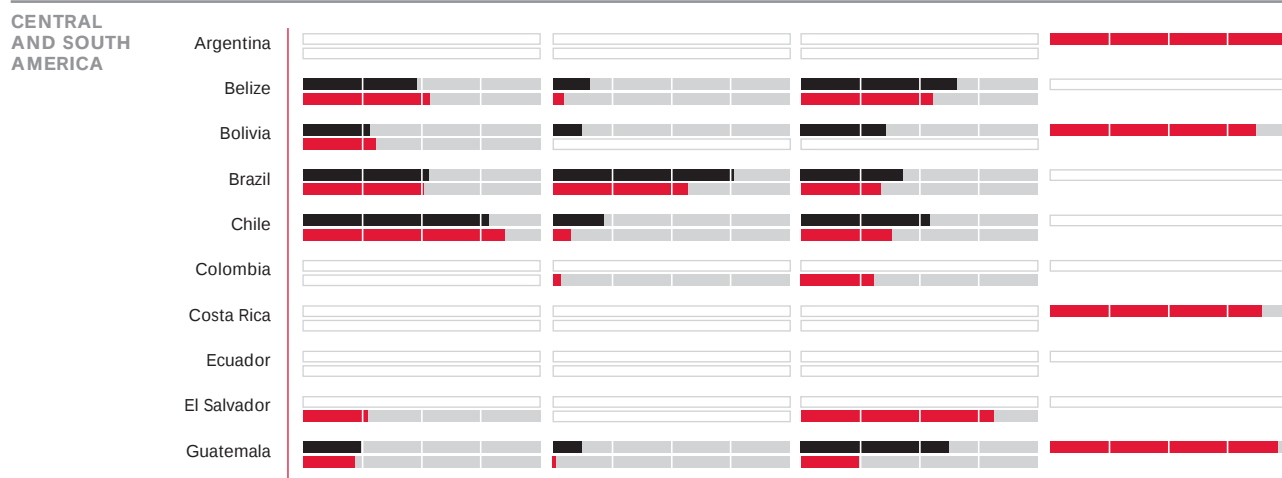
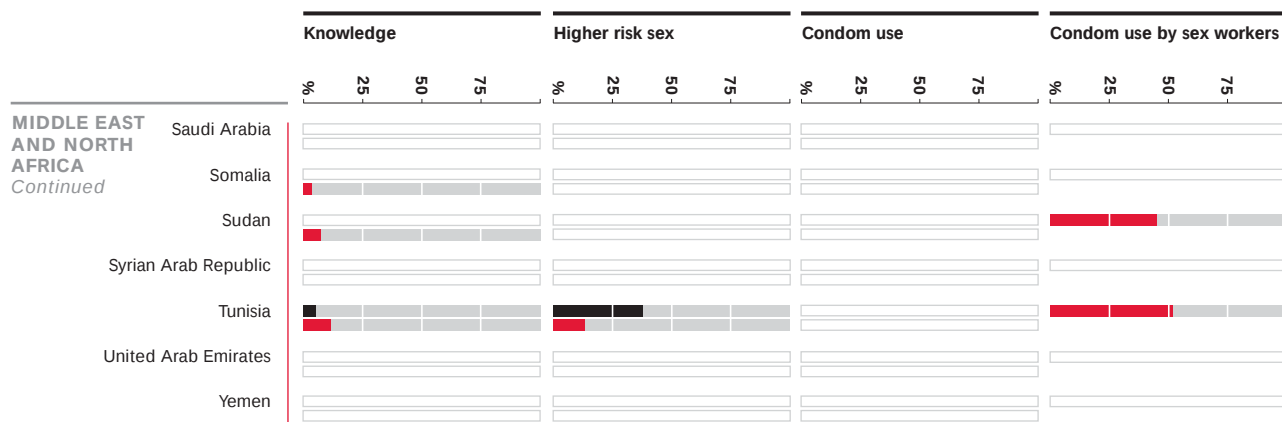




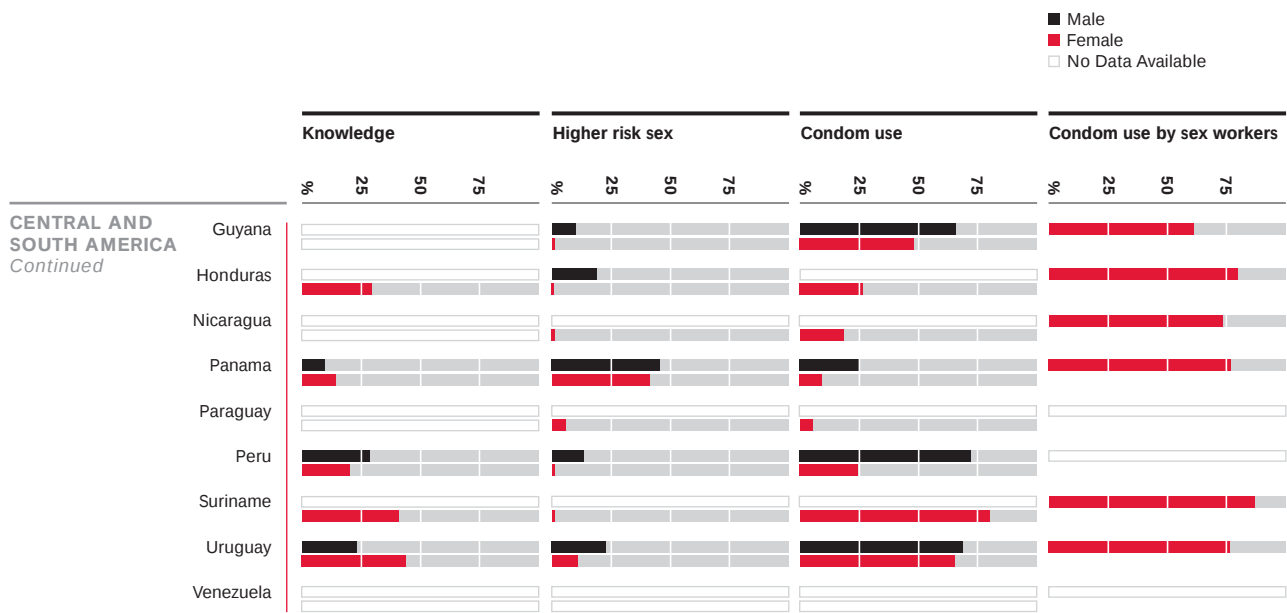
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HIV TREATMENT



KEY FINDINGS

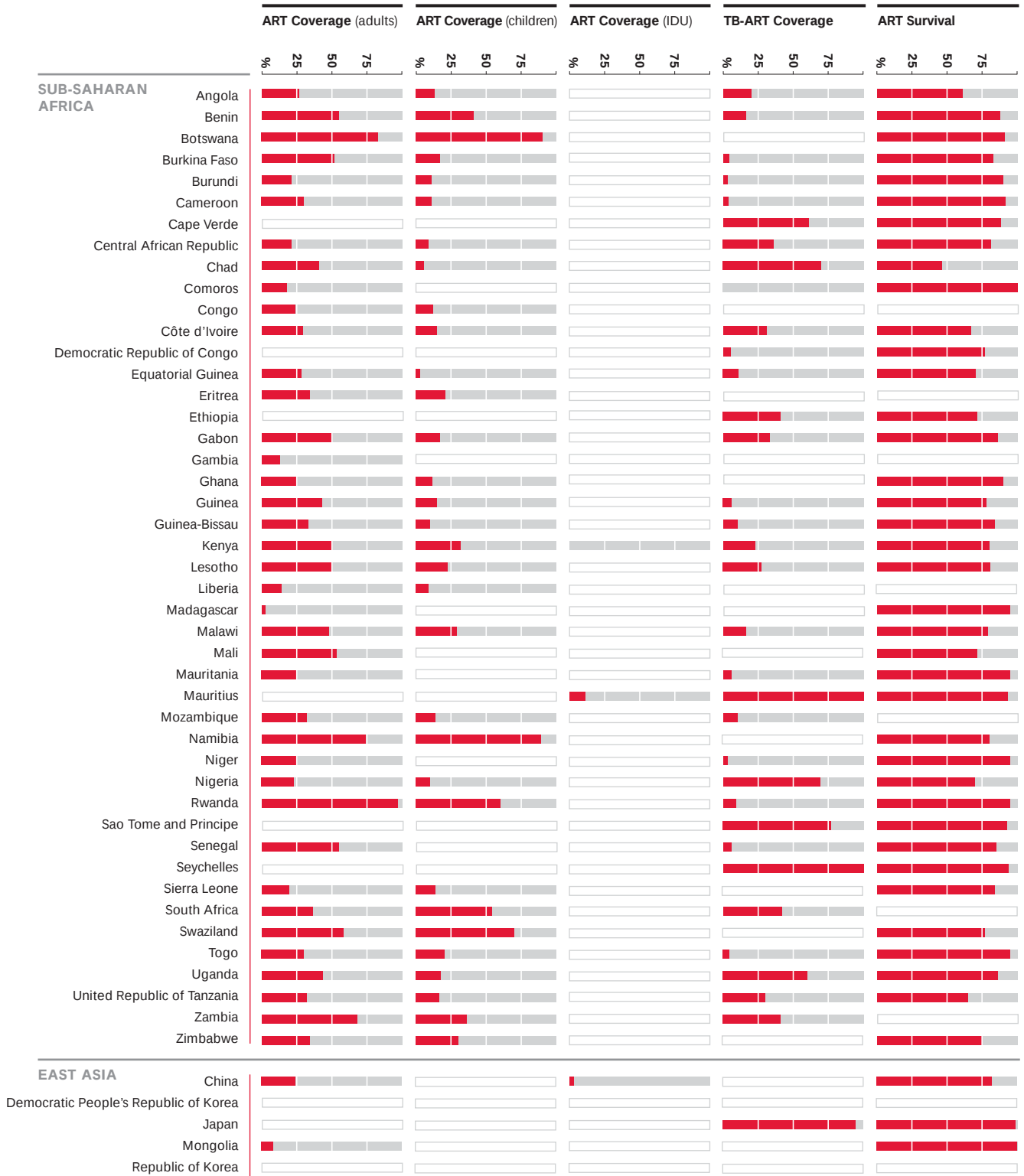
- An additional 1.2 million people received antiretroviral therapy in 2009, bringing the total number of people receiving treatment in low- and middle-income countries to 5.2 million, a 30% increase over 2008.
 - At the end of 2009, 36% (about 5.2 million) of the 15 million people in need in low- and middle-income countries were receiving antiretroviral therapy.
 - Fewer people are dying from AIDS-related causes. About 14.4 million life-years have been gained by providing antiretroviral therapy since 1996.
 - About 50% of pregnant women testing HIV positive were assessed for their eligibility to receive antiretroviral therapy for their own health.
 - Children and marginalized populations (such as people who inject drugs) are less likely to receive antiretroviral therapy than the population at large.
 - While steady progress is being made in scaling up access to HIV services for people with tuberculosis (TB), the percentage of people with TB who received an HIV test in 2009 remained low, at 26%. Progress in scaling up TB services for people living with HIV is also very slow.
 - Children orphaned by AIDS were nearly as likely to attend school as other children.
 - The availability of palliative and home-based care services for people living with HIV remains uneven.
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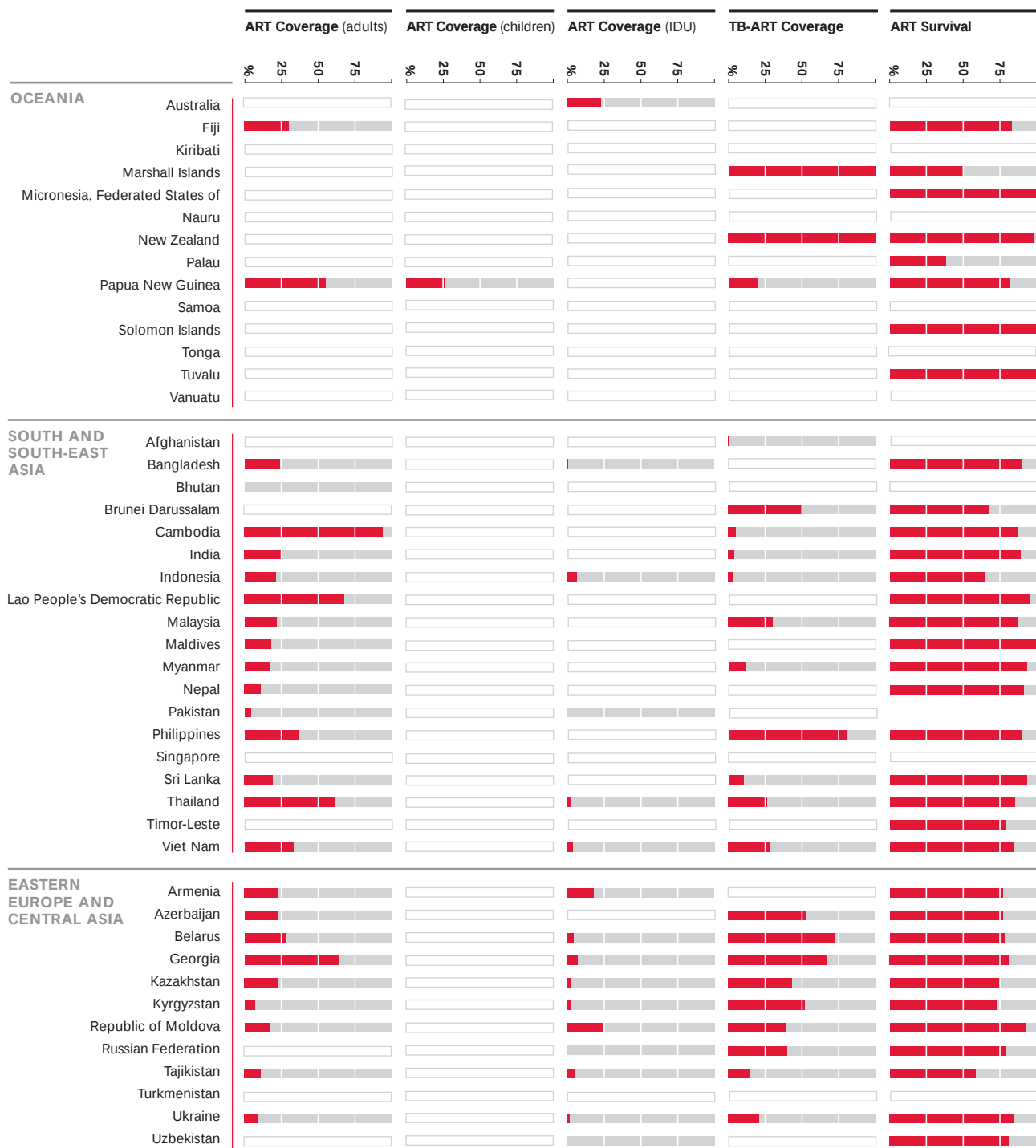
ACTION ITEMS

- HIV treatment must be scaled up to keep pace with increasing demand.
- HIV testing and counselling must be expanded, as most people get to know their status very late and access treatment later, which reduces the effectiveness of treatment programmes.
- An integrated HIV and TB programme is essential to meet the challenges posed by the dual epidemics.
- Maternal and child health services must be strengthened so that all pregnant women living with HIV can access comprehensive services for preventing maternal and child mortality and infants from becoming newly infected and for providing antiretroviral therapy for mothers.
- Children's access to antiretroviral therapy must improve. This will require maternal and child health and antiretroviral therapy centres to work closely together. In addition, better diagnostic tools and antiretroviral therapy formulations for children continue to be needed.
- Current approaches to treatment have not been optimal for the 15 million people in need. Treatment 2.0—a radically simplified treatment platform—holds promise to simplify treatment and provide all people needing it with a better pill less likely to lead to resistance, simpler diagnostics and monitoring, easier HIV testing, and more community empowerment. All stakeholders should unite to make this a reality.
- Social support for orphans must continue, and recent success in rolling out programmes of support such as cash transfers, food support, and education bursaries must be expanded and sustained.
- Investments in treatment have brought results for AIDS-related mortality and reducing the number of people newly infected with HIV. These investments must be continued and sustained over the long term.

SCORECARD: HIV TREATMENT

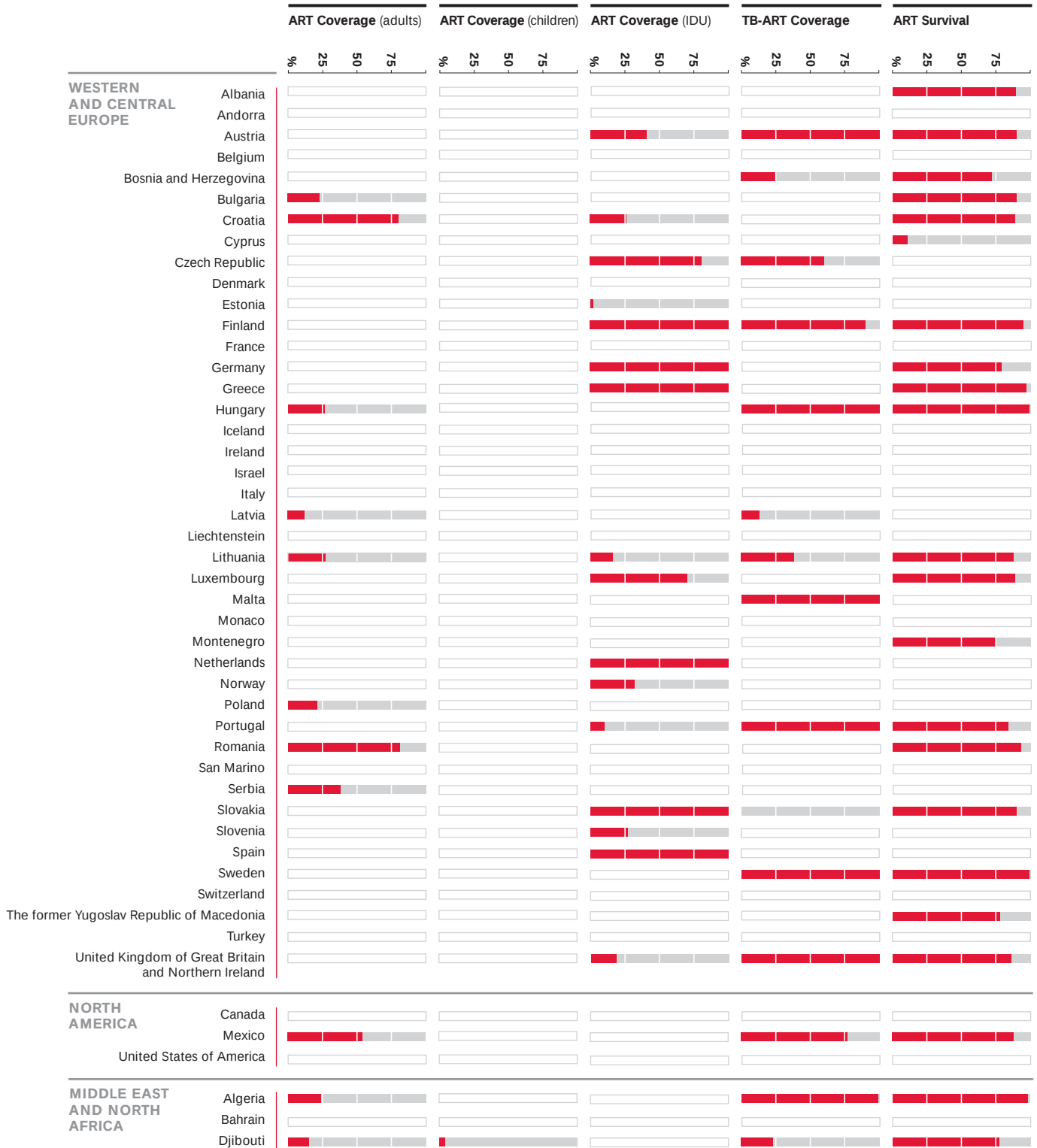
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SCORECARD: HIV TREATMENT

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HUMAN RIGHTS AND GENDER EQUALITY



KEY FINDINGS

HUMAN RIGHTS

- Failing to address the human rights of key populations at higher risk of exposure to HIV facilitates the growth of the epidemic and enhances its socially damaging effects.
- Punitive laws that affect people living with HIV, or other people at higher risk of exposure, remain widespread. Laws protecting such people exist in many countries, but there are not enough data to show whether they are actively or widely enforced.
- Stigma, discrimination, and violence against transgender people, and men who have sex with men, increase their risk of HIV infection and also for their male and female partners.

GENDER EQUALITY

- The vulnerability of women and girls to HIV remains particularly high in sub-Saharan Africa; 80% of all women in the world living with HIV live in this region.
- Efforts to promote universal access to HIV prevention, treatment, care and support services require a sharper focus on women and girls. Fewer than half of countries report having a specific budget for HIV-related programmes addressing women and girls.

ACTION ITEMS

HUMAN RIGHTS

- Laws, policies, and regulations that create obstacles to effective HIV responses are increasingly acknowledged. Countries should now take action to decriminalize sex workers, people who use drugs, men who have sex with men and transgender people, and reform other laws that block effective responses to HIV.
- Despite increased reporting on protective laws, countries and other stakeholders should establish effective enforcement mechanisms and provide people living with HIV and other key populations with access to justice and redress through HIV-related legal services and legal literacy programmes.
- Although progress has been noted, HIV-related stigma and discrimination are still highly prevalent globally and are not yet being sufficiently addressed. Countries and other stakeholders should urgently scale up comprehensive programmes that build capacities of HIV-related service providers, address stigma and discrimination in laws, institutions and communities, and empower those affected by HIV.
- To help to realize human rights in the context of HIV, there must be more meaningful involvement of people living with HIV and those vulnerable to HIV in national HIV responses, as well as meaningful coverage of all affected populations. The principle of greater involvement of people living with HIV must be fully implemented.

GENDER EQUALITY

- To achieve universal access goals towards HIV prevention, treatment, care and support, the AIDS response needs to be women and girls centred and include a dedicated budget to address their needs.
- Given that violence is widespread and that there is a clear association between violence against women and the spread of HIV, national HIV responses must include specific interventions to address violence.
- All countries need to ensure that women have access to integrated quality HIV and sexual and reproductive health services that enable women to exercise their rights.
- Men and boys need to be engaged in innovative approaches to change harmful social and cultural practices and norms, as part of HIV prevention.
- Countries need to address the needs of men who have sex with men through prevention interventions that go beyond health service provision.

SCORECARD: HUMAN RIGHTS AND GENDER EQUALITY

- Yes/Agree
- No/Disagree
- Data not available
- No NCPI report
- No UNGASS report
- A** NCPI Part A (government response)
- B** NCPI Part B (civil society response)

		Laws & regulations protecting people living with HIV against discrimination	Laws, regulations, policies protecting specific sub-populations	Laws, regulations, policies obstructing access to prevention, treatment, care and support for vulnerable subpopulations	Mechanism to record, document and address cases of discrimination experienced by people living with HIV, vulnerable subpopulations	Women as a specific component of the national strategic plan	Women component of the national strategic plan budgeted	IEC activities on fighting Violence Against Women
		B	A B	A B	B	A	A	A
SUB-SAHARAN AFRICA	Angola	■	■ ■	■ ■	■	■	□	■
	Benin	■	■ ■	■ ■	■	■	■	■
	Botswana	■	■ ■	■ ■	■	■	■	■
	Burkina Faso	■	■ ■	■ ■	■	■	□	■
	Burundi	■	■ ■	■ ■	■	■	■	■
	Cameroon	■	■ ■	■ ■	■	■	■	■
	Cape Verde	■	■ ■	■ ■	■	■	■	■
	Central African Republic	■	■ ■	■ ■	■	■	■	■
	Chad	■	■ ■	■ ■	■	■	■	■
	Comoros	■	■ ■	■ ■	■	■	■	■
	Congo	■	■ ■	■ ■	■	■	■	■
	Côte d'Ivoire	■	■ ■	■ ■	■	■	■	■
	Democratic Republic of Congo	■	■ ■	■ ■	■	■	■	■
	Equatorial Guinea	■	■ ■	■ ■	■	■	■	■
	Eritrea	■	■ ■	■ ■	■	■	■	■
	Ethiopia	■	■ ■	■ ■	■	■	■	■
	Gabon	■	■ ■	■ ■	■	■	■	■
	Gambia	■	■ ■	■ ■	■	■	■	■
	Ghana	■	■ ■	■ ■	■	■	■	■
	Guinea	■	■ ■	■ ■	■	■	■	■
	Guinea-Bissau	■	■ ■	■ ■	■	■	■	□
	Kenya	■	■ ■	■ ■	■	■	■	■
	Lesotho	■	■ ■	■ ■	■	■	■	■
	Liberia	■	■ ■	■ ■	■	■	■	■
	Madagascar	■	■ ■	■ ■	■	■	■	■
	Malawi	■	■ ■	■ ■	■	■	■	■
	Mali	■	■ ■	■ ■	■	■	■	■
	Mauritania	■	■ ■	■ ■	■	■	■	■
	Mauritius	■	■ ■	■ ■	■	■	■	■
	Mozambique	■	■ ■	■ ■	■	■	■	■
	Namibia	■	■ ■	■ ■	■	■	■	■
	Niger	■	■ ■	■ ■	■	■	■	■
	Nigeria	■	■ ■	■ ■	■	■	■	■
	Rwanda	■	■ ■	■ ■	■	■	■	■
	Sao Tome and Principe	■	■ ■	■ ■	■	■	■	■
	Senegal	■	■ ■	■ ■	■	■	■	■
	Seychelles	■	■ ■	■ ■	■	■	■	■
	Sierra Leone	■	■ ■	■ ■	■	■	■	■

		Laws & regulations protecting people living with HIV against discrimination	Laws, regulations, policies protecting specific sub-populations	Laws, regulations, policies obstructing access to prevention, treatment, care and support for vulnerable subpopulations	Mechanism to record, document and address cases of discrimination experienced by people living with HIV, vulnerable subpopulations	Women as a specific component of the national strategic plan	Women component of the national strategic plan budgeted	IEC activities on fighting Violence Against Women
		B	A B	A B	B	A	A	A
SUB-SAHARAN AFRICA <i>Continued</i>	South Africa	■	■ ■	■ ■	■	■	■	■
	Swaziland	■	■ ■	■ ■	■	■	■	■
	Togo	■	■ ■	■ ■	■	■	■	■
	Uganda	■	■ ■	■ ■	■	■	■	■
	United Republic of Tanzania	■	■ ■	■ ■	■	■	□	■
	Zambia	■	■ ■	■ ■	■	■	■	■
	Zimbabwe	■	■ ■	■ ■	■	■	■	■
EAST ASIA								
	China	■	■ ■	■ ■	■	■	■	■
	Democratic People's Republic of Korea	□	□ □	□ □	□	□	□	□
	Japan	■	□ ■	□ ■	■	□	□	□
	Mongolia	■	■ ■	■ ■	■	■	■	■
	Republic of Korea	□	□ □	□ □	□	□	□	□
OCEANIA								
	Australia	■	■ ■	■ ■	■	■	■	■
	Fiji	■	■ ■	■ ■	■	■	■	■
	Kiribati	□	□ □	□ □	□	□	□	□
	Marshall Islands	■	■ ■	■ ■	■	■	□	■
	Micronesia, Federated States of	■	■ ■	■ ■	■	□	□	□
	Nauru	■	■ ■	■ ■	■	□	□	■
	New Zealand	■	■ ■	■ ■	■	□	□	□
	Palau	■	■ ■	■ ■	■	■	■	■
	Papua New Guinea	■	■ ■	■ ■	■	■	■	■
	Samoa	■	■ ■	■ ■	■	■	■	■
	Solomon Islands	■	■ ■	■ ■	■	■	■	■
	Tonga	■	■ ■	■ ■	■	■	■	■
	Tuvalu	■	■ ■	■ ■	■	■	■	■
	Vanuatu	■	■ ■	■ ■	■	■	■	□
SOUTH AND SOUTH-EAST ASIA								
	Afghanistan	■	■ ■	■ ■	■	■	■	■
	Bangladesh	■	■ ■	■ ■	■	■	■	■
	Bhutan	□	□ □	□ □	□	□	□	□
	Brunei Darussalam	■	■ ■	■ ■	■	□	□	□
	Cambodia	■	■ ■	■ ■	■	■	■	■
	India	■	■ ■	■ ■	■	■	■	■
	Indonesia	■	■ ■	■ ■	■	■	■	■
	Lao People's Democratic Republic	■	■ ■	■ ■	■	■	■	■
	Malaysia	■	■ ■	■ ■	■	■	■	■

SCORECARD: HUMAN RIGHTS AND GENDER EQUALITY

- Yes/Agree
- No/Disagree
- Data not available
- No NCPI report
- No UNGASS report
- A** NCPI Part A (government response)
- B** NCPI Part B (civil society response)

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		B	A B	A B	B	A	A	A
SOUTH AND SOUTH-EAST ASIA								
<i>Continued</i>								
	Maldives	■	■ ■	■ ■	■	■	■	■
	Myanmar	■	■ ■	■ ■	■	■	■	■
	Nepal	■	■ ■	■ ■	■	■	■	
	Pakistan	■	■ ■	■ ■	■	■	■	■
	Philippines	■	■ ■	■ ■	■	■	■	■
	Singapore	■	■ ■	■ ■	■	■	■	
	Sri Lanka	■	■ ■	■ ■	■	■	■	■
	Thailand	■	■ ■	■ ■	■	■	■	■
	Timor-Leste	■	■ ■	■ ■	■	■		■
	Viet Nam	■	■ ■	■ ■	■	■	■	■
EASTERN EUROPE AND CENTRAL ASIA								
	Armenia	■	■ ■	■ ■	■	■	■	
	Azerbaijan	■	■ ■	■ ■	■	■		■
	Belarus	■	■ ■	■ ■	■	■	■	■
	Georgia	■	■ ■	■ ■	■	■		
	Kazakhstan	■	■ ■	■ ■	■	■	■	■
	Kyrgyzstan	■	■ ■	■ ■	■	■	■	■
	Moldova, Republic of	■	■ ■	■ ■	■	■	■	■
	Russian Federation	■	■ ■	■ ■	■	■	■	■
	Tajikistan	■	■ ■	■ ■	■	■	■	■
	Turkmenistan		 	 				
	Ukraine	■	■ ■	■ ■	■	■	■	■
	Uzbekistan	■	■ ■	■ ■	■	■	■	■
WESTERN AND CENTRAL EUROPE								
	Albania		 	 				
	Andorra		 	 				
	Austria		 	 				
	Belgium	■	 ■	 ■	■			■
	Bosnia and Herzegovina	■	■ ■	■ ■	■	■	■	■
	Bulgaria	■	■ ■	■ ■	■	■	■	
	Croatia	■	■ ■	■ ■	■	■	■	
	Cyprus		 	 				
	Czech Republic	■	■ ■	■ ■	■	■	■	
	Denmark	■	■ ■	■ ■	■	■	■	
	Estonia	■	■ ■	■ ■	■	■		■
	Finland	■	■ ■	■ ■	■			
	France		 	 				
	Germany	■	■ ■	■ ■	■	■		■

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		B	A B	A B	B	A	A	A	
WESTERN AND CENTRAL EUROPE <i>Continued</i>	Greece	■	■ ■	■ ■	■	■	■	■	
	Hungary	■	■ ■	■ ■	■	■	■	□	
	Iceland	□	□ □	□ □	□	□	□	□	
	Ireland	■	■ □	■ ■	■	■	■	■	
	Israel	■	■ ■	■ ■	■	□	□	□	
	Italy	■	■ ■	■ ■	■	■	■	■	
	Latvia	■	■ ■	■ ■	■	■	■	□	
	Liechtenstein	□	□ □	□ □	□	□	□	□	
	Lithuania	■	■ ■	■ ■	■	■	■	■	
	Luxembourg	■	■ ■	■ ■	■	■	■	□	
	Malta	□	■ □	■ □	□	■	□	□	
	Monaco	■	■ ■	■ ■	■	■	■	■	
	Montenegro	■	■ ■	■ ■	■	■	■	■	
	Netherlands	■	■ ■	■ ■	■	□	□	■	
	Norway	■	■ ■	■ ■	■	■	■	■	
	Poland	■	■ ■	■ ■	■	■	■	■	
	Portugal	■	■ ■	■ ■	■	■	■	■	
	Romania	■	■ ■	■ ■	■	■	■	■	
	San Marino	□	□ □	□ □	□	□	□	□	
	Serbia	■	■ ■	■ ■	■	■	■	■	
	Slovakia	■	■ ■	■ ■	■	■	■	■	
	Slovenia	■	■ ■	■ ■	■	■	■	□	
	Spain	■	■ ■	■ ■	■	■	■	■	
	Sweden	■	■ ■	■ ■	■	■	■	■	
	Switzerland	■	■ ■	■ ■	■	■	■	□	
	The former Yugoslav Republic of Macedonia	■	■ ■	■ ■	■	■	■	□	
	Turkey	■	■ ■	■ ■	■	■	■	■	
	United Kingdom of Great Britain & Northern Ireland	■	■ ■	■ ■	■	■	■	■	
	NORTH AMERICA								
	Canada	■	■ ■	■ ■	■	■	■	■	
	Mexico	■	■ ■	■ ■	■	■	■	■	
	United States of America	■	■ ■	■ □	■	□	□	□	
MIDDLE EAST AND NORTH AFRICA									
	Algeria	■	■ ■	■ ■	■	■	■	■	
	Bahrain	■	■ ■	■ ■	■	■	■	□	
	Djibouti	■	■ ■	■ ■	■	■	■	■	

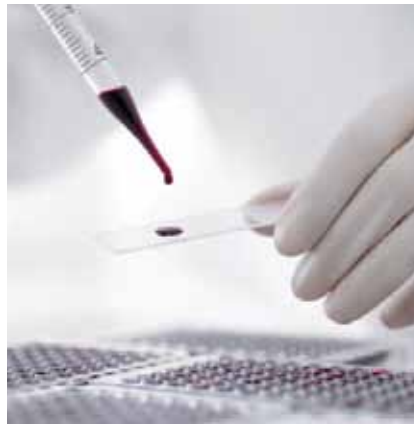
SCORECARD: HUMAN RIGHTS AND GENDER EQUALITY

- Yes/Agree
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		B	A B	A B	B	A	A	A
MIDDLE EAST AND NORTH AFRICA <i>Continued</i>	Egypt	■	■ ■	■ ■	■	■	■	■
	Iran, Islamic Republic of	■	■ ■	■ ■	■	■	■	□
	Iraq	□	□ □	□ □	□	□	□	□
	Jordan	■	■ ■	■ ■	■	■	■	■
	Kuwait	■	■ ■	■ ■	■	■	■	□
	Lebanon	■	■ ■	■ ■	■	■	■	■
	Libyan Arab Jamahiriya	■	■ ■	■ ■	■	□	□	■
	Morocco	■	■ ■	■ ■	■	■	■	■
	Oman	■	■ ■	■ □	■	■	■	□
	Qatar	□	■ □	■ □	□	□	□	□
	Saudi Arabia	■	■ ■	■ ■	■	■	■	□
	Somalia	■	■ ■	■ ■	■	■	■	■
	Sudan	□	□ □	□ □	□	□	□	□
	Syrian Arab Republic	■	■ ■	■ ■	■	□	□	□
	Tunisia	■	■ ■	■ ■	■	■	■	□
	United Arab Emirates	■	■ ■	■ ■	■	□	□	□
	Yemen	■	■ ■	■ ■	■	■	■	■
CARIBBEAN	Antigua & Barbuda	■	■ ■	■ ■	■	□	□	■
	Bahamas	■	■ ■	■ ■	■	■	■	■
	Barbados	■	■ ■	■ ■	■	■	■	■
	Cuba	■	■ ■	■ ■	■	■	■	■
	Dominica	■	■ ■	■ ■	■	■	■	■
	Dominican Republic	■	■ ■	■ ■	■	■	■	■
	Grenada	■	■ ■	■ ■	■	■	■	■
	Haiti	■	■ ■	■ ■	■	■	■	■
	Jamaica	■	■ ■	■ ■	■	■	■	□
	Saint Kitts and Nevis	■	■ ■	■ ■	■	■	■	□
	Saint Lucia	■	■ ■	■ ■	■	■	■	■
	Saint Vincent and the Grenadines	■	■ ■	■ ■	■	■	■	■
	Trinidad and Tobago	■	■ ■	■ ■	■	■	■	□
CENTRAL AND SOUTH AMERICA	Argentina	■	■ ■	■ ■	■	■	■	■
	Belize	■	■ ■	■ ■	■	■	■	■
	Bolivia	■	■ ■	■ ■	■	■	■	■
	Brazil	■	■ ■	■ ■	■	■	■	■
	Chile	■	■ ■	■ ■	■	■	■	□
	Colombia	■	■ ■	■ ■	■	■	■	■

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		B	A B	A B	B	A	A	A
CENTRAL AND SOUTH AMERICA								
<i>Continued</i>								
	Costa Rica	■	■ ■	■ ■	■	■	■	□
	Ecuador	■	■ ■	■ ■	■	■	■	□
	El Salvador	■	■ ■	■ ■	■	■	■	□
	Guatemala	■	■ ■	■ ■	■	■	■	■
	Guyana	■	■ ■	■ ■	■	■	■	■
	Honduras	■	■ ■	■ ■	■	■	■	□
	Nicaragua	■	■ ■	■ ■	■	■	■	■
	Panama	■	■ ■	■ ■	■	■	■	■
	Paraguay	■	■ ■	■ ■	■	■	■	■
	Peru	■	■ ■	■ ■	■	■	□	■
	Suriname	■	■ ■	■ ■	■	■	■	□
	Uruguay	■	■ ■	■ ■	■	■	■	■
	Venezuela	■	■ ■	■ ■	■	■	■	■

HIV INVESTMENTS



KEY FINDINGS

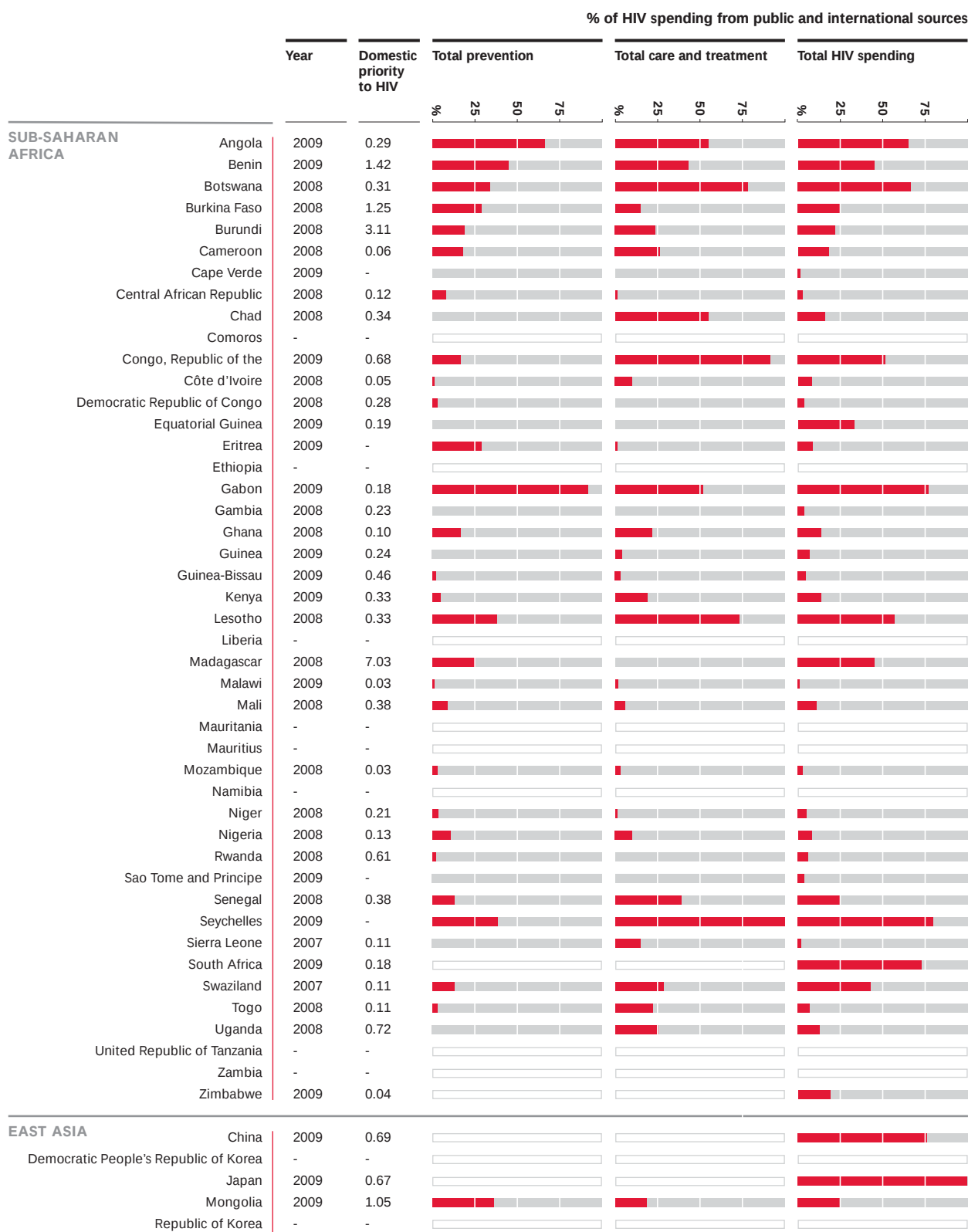
- A total of US\$ 15.9 billion was available for the AIDS response in 2009, US\$ 10 billion short of what is needed in 2010.
 - In low and middle income countries, domestic resources account for over half of all AIDS-related investments. In low-income countries, however, 88% of spending on AIDS comes from international funding.
 - The majority of international funding for AIDS comes from bilateral donors. The United States of America is the largest international donor.
 - Investment in treatment and care is increasing—but many countries depend on international assistance for their treatment and care programmes.
 - HIV prevention programmes largely rely on international funds.
 - One third of countries make the AIDS response a high budgetary priority, based on disease burden and national income.
-

ACTION ITEMS

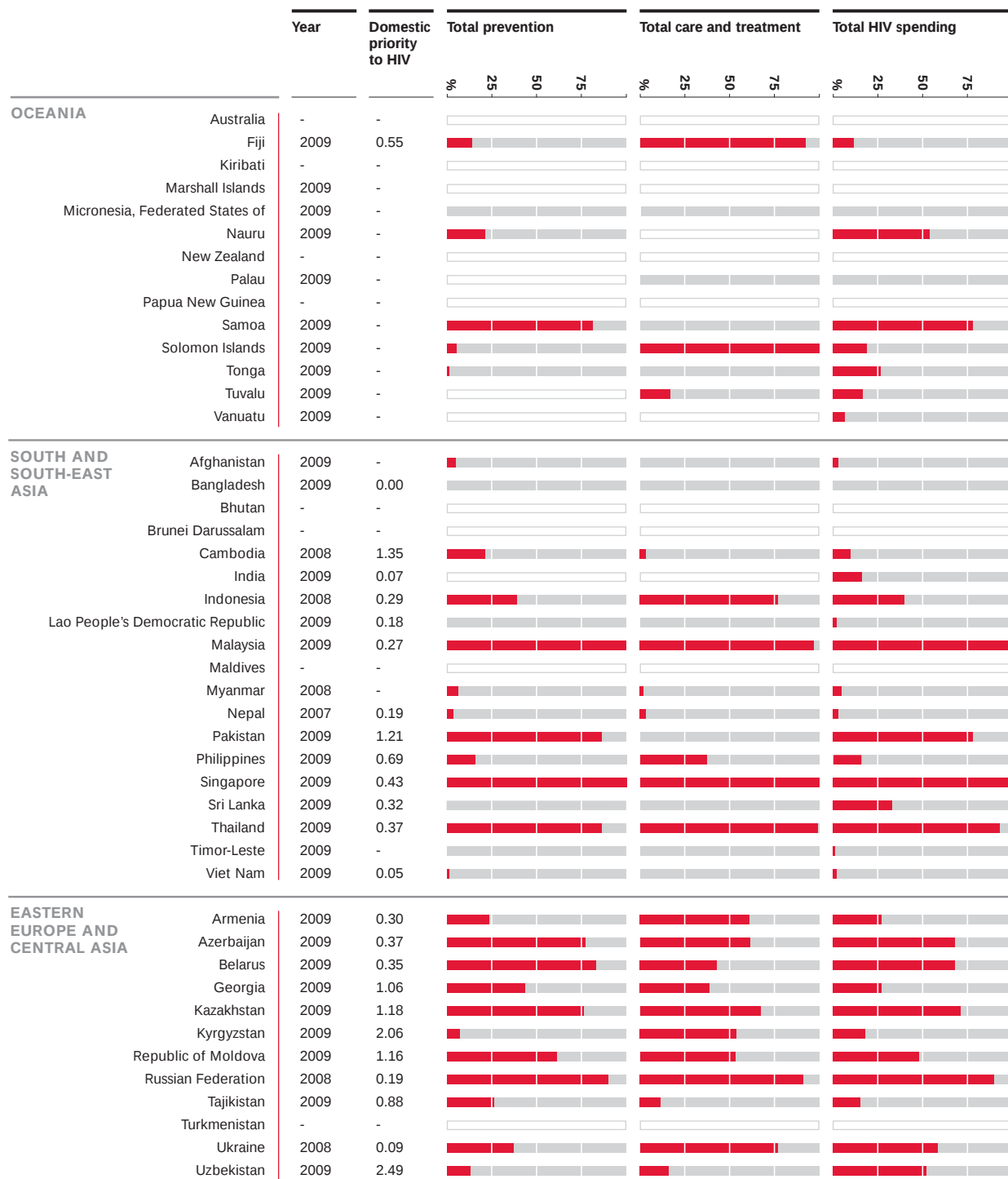
- The AIDS response must be fully funded. This is a shared responsibility between governments, donor countries, civil society and the private sector.
- Donor countries must continue to increase their allocations to the AIDS response.
- Countries that have the potential to increase domestic investments must do so to accelerate progress towards universal access to HIV prevention, treatment, care, and support.
- Resources for AIDS programmes must be predictable. National strategic plans must be realistic.
- Each national programme should set priorities to ensure that available resources are invested appropriately in cost-effective programmes.
- Donor investments must match country priorities.
- Investments must be evidence informed and reach populations most in need first so that the returns are maximized and meet human rights standards.
- HIV treatment programmes should be expanded urgently and utilize optimal combinations of high-quality and less-toxic drugs that reduce mortality over the long term.
- HIV prevention investments are cost-effective when they include combination approaches that maximize synergies rather than isolated interventions.

SCORECARD: HIV INVESTMENTS

Public
International
Data not available

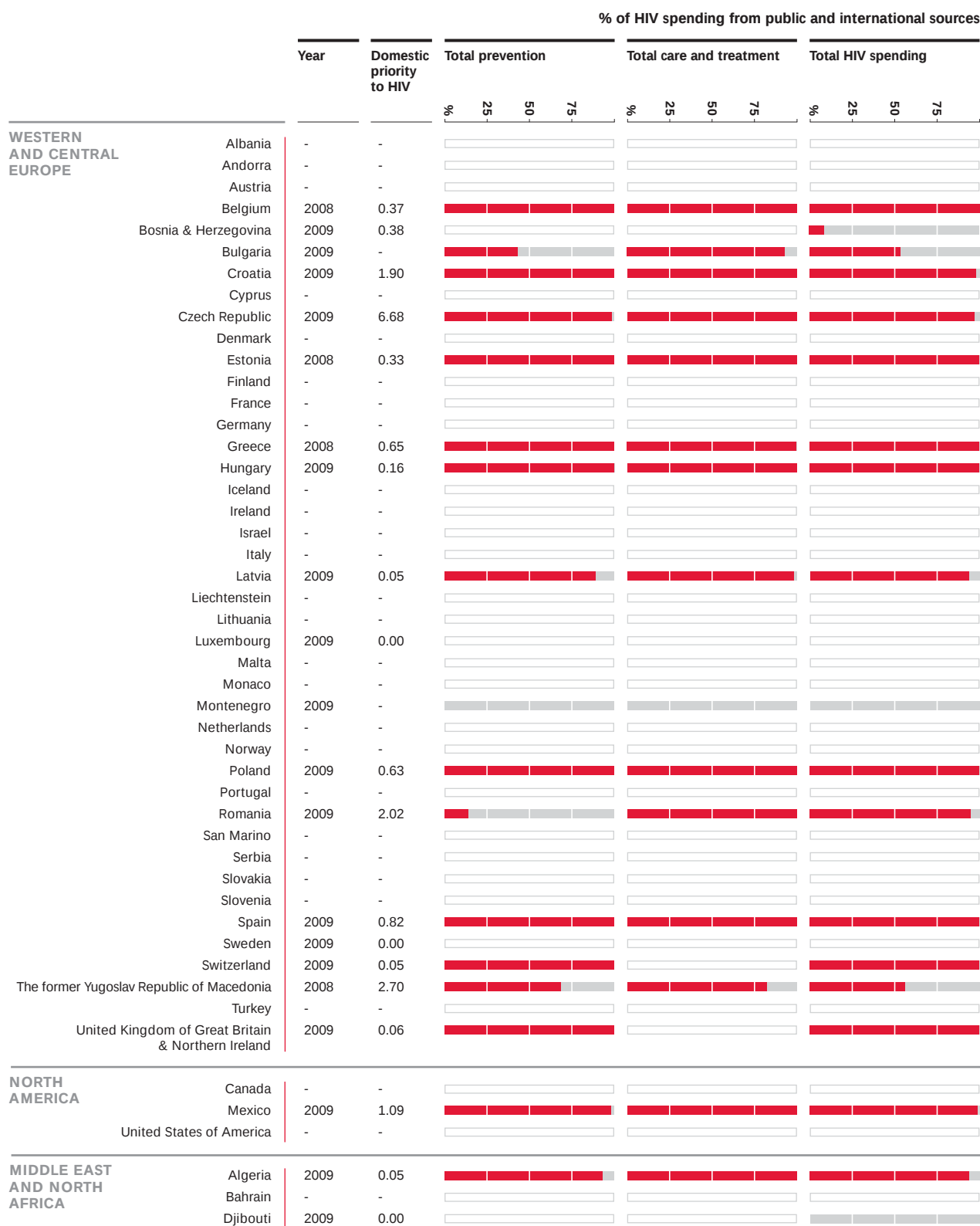


% of HIV spending from public and international sources

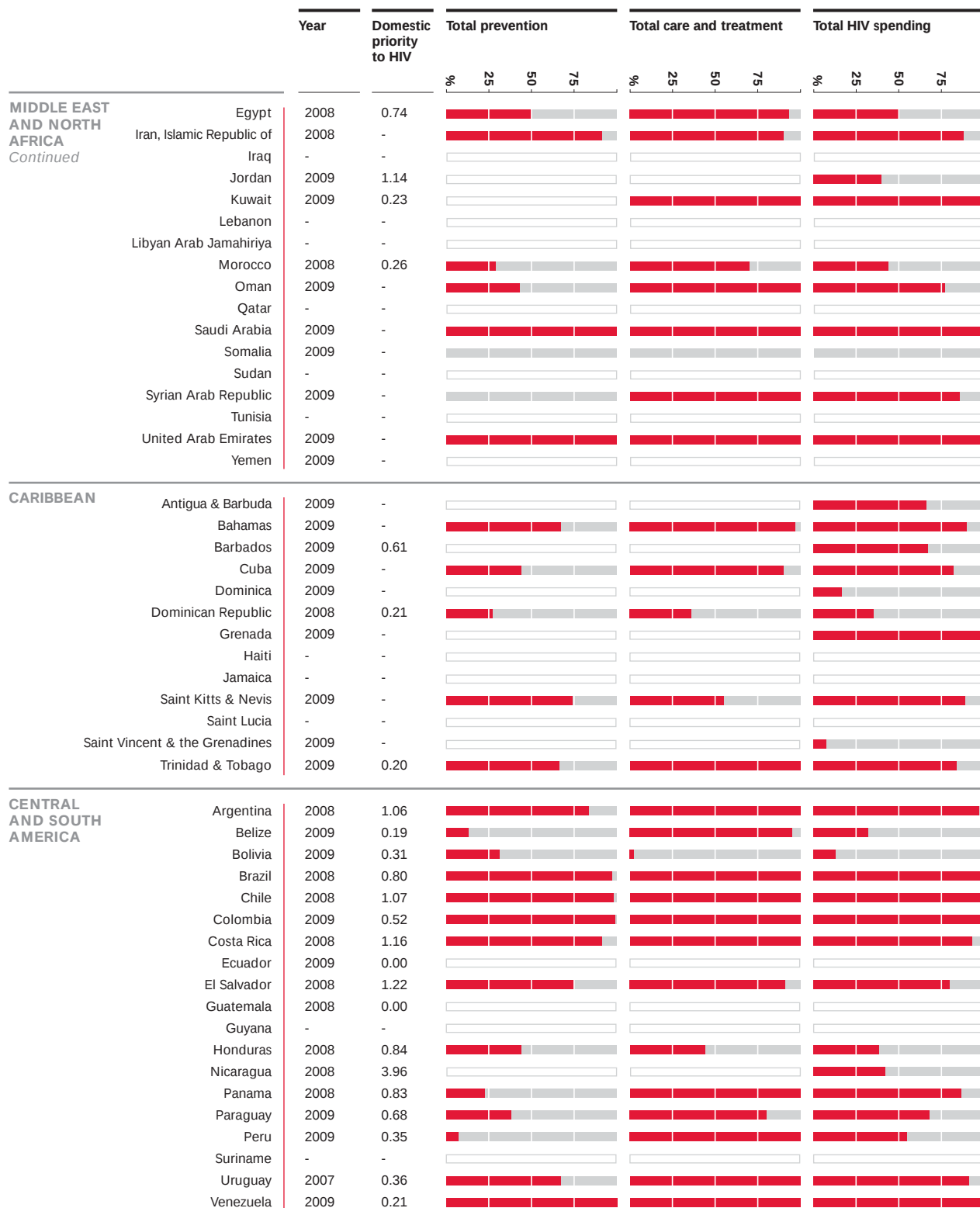


SCORECARD: HIV INVESTMENTS

Public
International
Data not available



% of HIV spending from public and international sources





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