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Follow-up to the outcome of the twenty-sixth special session: implementation of the Declaration of Commitment on HIV/AIDS

Declaration of Commitment on HIV/AIDS: five years later

Report of the Secretary-General

Summary

The present report provides an update on progress in the global AIDS response since the 2001 special session, identifies critical challenges that must be addressed and makes urgent recommendations to strengthen efforts at the global, regional and country levels.

The report is based on data supplied by countries on the complete set of core indicators developed by the Joint United Nations Programme on HIV/AIDS (UNAIDS) to monitor implementation of the Declaration of Commitment on HIV/AIDS. Nearly 120 country progress reports have been submitted that update the data provided by countries in 2003. These have been supplemented by over 30 reports from civil society, as well as by national and global surveys and coverage estimates for specific programmatic interventions.

Five years after the 2001 special session, the available evidence underscores the great diversity among countries and regions in implementing the response envisioned in the Declaration of Commitment on HIV/AIDS. While certain countries have reached key targets and milestones for 2005 as set out in the Declaration, many countries have failed to fulfil the pledges.

The central message of the present report is that a quarter of a century into the epidemic, the global AIDS response stands at a crossroads. The important progress made against AIDS since the special session — particularly in terms of greater resources, stronger national policy frameworks, wider access to treatment and prevention services and broad consensus on the principles of effective country-level action — provides a solid foundation on which to build a comprehensive full-scale response. In effect, for the first time ever the world possesses the means to begin to reverse the global epidemic. But success will require unprecedented willingness on

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the part of all actors in the global response to fulfil their potential, embrace new ways of working with each other and be committed to sustaining the response over the long term.

Failure to urgently strengthen the AIDS response will mean that the world will achieve neither the 2010 targets of the Declaration of Commitment nor Millennium Development Goal 6. And without major progress in tackling AIDS, global efforts to achieve the Millennium Development Goals of reducing poverty, hunger and childhood mortality will similarly fall short of agreed targets. Countries whose development is already flagging because of AIDS will continue to weaken, potentially threatening social stability and national security.

I. Introduction

1. When the AIDS epidemic was first detected 25 years ago, few could have imagined the devastating impact it would have on our world. To date, more than 65 million people have been infected with HIV, more than 25 million people have died and nearly 1 in 20 children in sub-Saharan Africa have been orphaned by AIDS. AIDS is now the world's leading cause of premature death among both men and women aged 15 to 59. Among the 40 million people currently living with HIV, more than 95 per cent are in developing countries. In the hardest-hit countries the very foundations of society, governance and national security are being eroded, stretching traditional safety nets to the breaking point and leading to social and economic repercussions that are likely to span generations.

2. The *Human Development Report 2005*[1] identified AIDS as having inflicted the single greatest reversal in human development. Still in its early stages, the pandemic is rapidly globalizing, affecting new countries as well as new populations within countries where the epidemic is already well established. The AIDS burden is growing especially severe for women and girls. Not only is AIDS an unprecedented public health challenge, it represents a profound threat to prospects for poverty reduction, child survival and economic development.

3. The special session of the General Assembly on HIV/AIDS, held in June 2001, represented a landmark in global efforts to respond to the AIDS crisis. For the first time in the history of the epidemic, leaders from 189 Member States committed to mounting an unprecedented, long-term, comprehensive response to HIV, as measured by a series of time-bound targets set out in the Declaration of Commitment on HIV/AIDS (resolution S-26/2). In the years following the special session, the Declaration of Commitment has galvanized global action, strengthened advocacy by civil society and helped guide national decision-making.

4. Much has been accomplished. Total financing for HIV programmes in developing countries increased more than fourfold between 2001 and 2005. The number of people on antiretroviral therapy has increased fivefold, and a comparable rise has occurred in the number who chose to learn their HIV serostatus. More and more countries have made headway against their epidemics through prevention efforts, including Cambodia, Kenya and Zimbabwe, where surveillance has documented notable declines in the prevalence of HIV. Reflecting a powerful desire to use every available AIDS dollar as effectively as possible, a strong global consensus has coalesced around the "three ones" principles for effective country-level action on AIDS, which call for all actors to align their activities with nationally owned and determined national strategies and coordinating mechanisms. Efforts against the pandemic have strengthened to the degree that the global community has now committed to a common endeavour to massively scale up essential HIV prevention, treatment, care and support services, and come as close as possible to universal access to treatment by 2010.

5. Yet the epidemic continues to outpace the global response. In 2005 there were more new infections and more AIDS deaths than ever before. Despite recent gains, only about one in five people in low- and middle-income countries who need antiretroviral drugs are currently obtaining them, and the number of people who require such therapy will continue to rise just from those already infected. In many countries, progress in scaling up proven HIV prevention methods appears to have

stalled. Key prevention services, such as focused behaviour change programmes for highly vulnerable and at-risk populations, and services to prevent mother-to-child HIV transmission currently reach fewer than 10 per cent of those who need them.

6. Five years after the 2001 special session, the available evidence underscores the extraordinary diversity between countries and regions in implementing the response envisioned in the Declaration of Commitment. While select countries have reached key targets and milestones for 2005, set out in the Declaration of Commitment, many countries have failed to fulfil the pledges specified in the Declaration. Some countries have made great strides in expanding access to treatment but have made little progress in scaling up HIV prevention programmes, while other countries that are now experiencing a reduction in national HIV prevalence are making only slow progress to ensure that treatment is available to those who need it. Overall progress towards the agreed global targets for 2005 is set out in the table below. The size of the range on almost every indicator reflects the diversity of performance across countries.

7. Unless the AIDS response becomes substantially stronger, more strategic and better coordinated, the world will not achieve the 2010 targets of the Declaration of Commitment and countries most affected by AIDS will fail to achieve the Millennium Development Goals of reducing poverty, hunger and childhood mortality. Indeed, countries whose development is already flagging because of AIDS will continue to weaken, potentially threatening social stability and national security.

8. A quarter-century into the epidemic, the global AIDS response stands at a crossroads. Because of the stronger response mobilized since the special session, for the first time ever the world possesses the means to begin to reverse the global epidemic in the next 10 years. Expanding available prevention strategies worldwide would avert more than half of all HIV infections projected to occur between 2005 and 2015 and save $24 billion in associated treatment costs.[2] Mounting a comprehensive response to reverse the epidemic will require significantly greater resources to scale up evidence-based strategies, unprecedented commitment to tackling obstacles to success and new ways of doing business among key actors. With 14,000 new infections and 8,000 deaths occurring daily, time is of the essence.

Progress towards Declaration of Commitment on HIV/AIDS global targets: low- and middle-income countries, 2005

Global results	*Global targets*
Total annual expenditure	
$8,297,000,000 Estimated range: $7.4 billion-$8.5 billion	$7.0-$10.0 billion
Percentage of youth aged 15-24 who correctly identify ways of preventing HIV transmission	
Males 33% (Country range: 7%-50% coverage)	90% coverage
Females 20% (Country range: 8%-44% coverage)	
Percentage of HIV-positive pregnant women receiving antiretroviral prophylaxis	
9% (Country range: 1%-59% coverage)	80% coverage
Percentage of people with advanced HIV infection receiving antiretroviral therapy	
20% (Country range: 1%-100% coverage)	50% coverage
1,300,000 persons on treatment	3 million by 2005
Percentage of young men and women aged 15-24 who are HIV-infected	
Women: 4.1% (Measure of uncertainty: 3.2%-5.1%)	
Men: 1.6% (Measure of uncertainty: 1.2%-2.0%)	25% reduction in most-affected countries
No comparable global data on this age cohort is available from 2001. Progress towards target can only be measured in individual countries.	
Estimated percentage of infants born to HIV-infected mothers who are infected in 2005	
26% (in countries with generalized epidemics)	
There has been an estimated 10% reduction in HIV transmission between 2001 and 2005.	20% reduction

II. Key findings and recommendations

9. At the request of the General Assembly (see resolution 60/224), the present report provides an update on progress in the global AIDS response since the 2001 special session, identifies critical challenges that must be addressed and makes urgent recommendations to strengthen AIDS efforts at the global, regional and country levels. Much of the information in the report is derived from data supplied by countries with respect to core indicators developed by UNAIDS and its research partners to monitor implementation of the Declaration of Commitment. Nearly 120 country progress reports update the data provided by countries in 2003, permitting identification of trends against the core indicators. To obtain the fullest possible picture on progress in the global response since the special session, country reports

have been supplemented by information provided by civil society in more than 30 reports, as well as by national and global surveys and by coverage estimates for specific programmatic interventions.

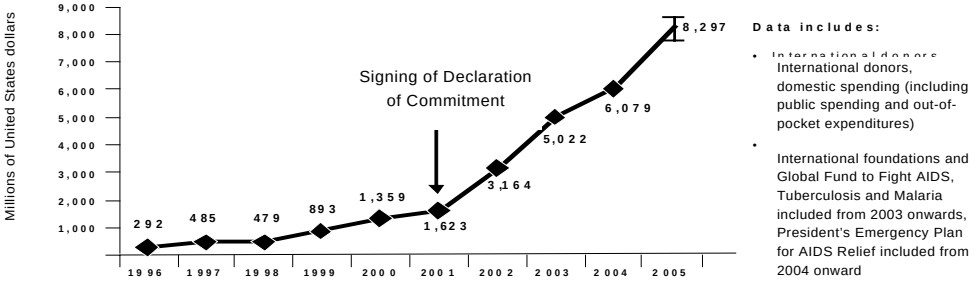
10. Key findings of the report include the following:

(a) In most countries, a strong foundation now exists on which to build an effective AIDS response. A total of 90 per cent of reporting countries now have a national AIDS strategy, and 85 per cent have a single national body to coordinate AIDS efforts. In nearly 40 developing countries, the national AIDS response is now personally led by heads of Government or their deputies;

(b) Financial resources for AIDS have significantly increased, but more funding will be needed to support a response capable of reversing the epidemic. The pace of increase in AIDS resources has accelerated since the special session, as demonstrated in figure 1 below. In 2005, approximately $8.3 billion was spent on AIDS programmes in low- and middle-income countries, reaching the financing target in the Declaration of Commitment of between $7 billion and $10 billion;

Figure 1

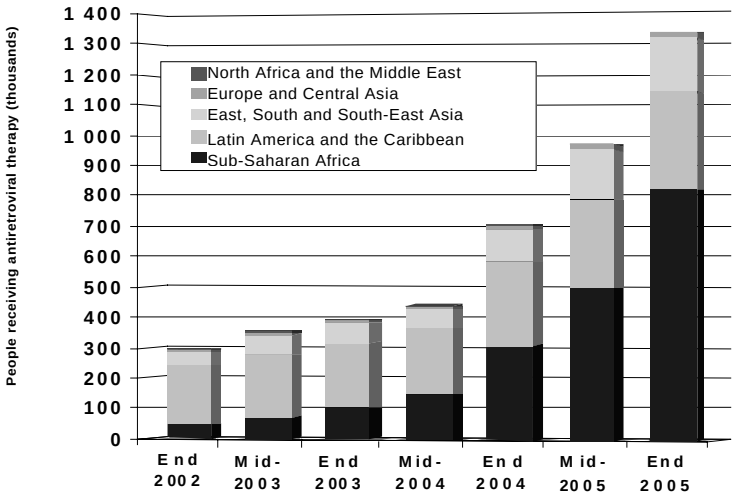
Estimated total annual resources available for AIDS, 1996-2005



(c) Treatment access has greatly expanded, although such efforts have fallen short of global goals. Although the world fell short of the global goal of having 3 million people on antiretroviral treatment by the end of 2005, the "3 by 5" initiative conclusively demonstrated the feasibility of administering antiretroviral drugs in resource-limited settings, with 1.3 million people in developing countries now benefiting from access to such drugs (see figure 2). Twenty-four countries have met or exceeded the "3 by 5" target of 50 per cent coverage of those in need of treatment;

Figure 2

Number of people receiving antiretroviral therapy in low- and middle-income countries, end 2002 to end 2005



(d) Some countries have dramatically increased access to HIV prevention programmes. In more than 70 countries surveyed, utilization of testing and counselling services quadrupled in the past five years from roughly 4 million in 2001 to 16.5 million in 2005. A total of 74 per cent of primary schools and 81 per cent of secondary schools in 58 countries that provided reporting data now provide AIDS education. Some countries have achieved nearly 70 per cent coverage of pregnant women, with services to prevent mother-to-child transmission (though the global average is only 9 per cent). Blood for use in transfusions is now routinely screened for HIV in most countries;

(e) Despite progress in expanding access to HIV prevention and treatment, the epidemic continues to worsen, especially among women and young people. Whereas AIDS once primarily affected men, women now represent half of all people living with HIV, including nearly 60 per cent in Africa. Over half of all new HIV infections are in young people aged 15 to 24. In parts of Africa and the Caribbean, young women (15-24) are up to six times more likely to be HIV-infected than young men;

(f) HIV prevention programmes are failing to reach the populations most at risk. Only 9 per cent of men who have sex with men received any type of HIV prevention service in 2005, with service coverage ranging from 4 per cent in Eastern Europe and Central Asia to 24 per cent in Latin America and the Caribbean. Among people who inject drugs, fewer than one in five received HIV prevention services, with especially low coverage (10 per cent) reported in Eastern Europe and Central Asia, where drug use is driving the rapid expansion of HIV. Twenty-four countries reported on the percentage of sex workers reached by any prevention programmes, of which nine achieved coverage rates greater than 50 per cent. Nineteen countries reported that more than 50 per cent of sex workers had used a condom with their last client. Even though the data indicate that coverage of prevention programmes is

higher in sex workers than in men who have sex with men and injecting drug users, additional efforts are critical to ensure an adequate rate of coverage in all three groups;

(g) HIV prevention efforts remain notably inadequate for young people, who account for half of all new infections, but there is still evidence of positive behaviour change. Although the Declaration of Commitment provided that 90 per cent of young people would be knowledgeable about HIV by 2005, surveys indicate that fewer than 50 per cent of young people are properly educated about HIV. On a more encouraging note, the percentage of young people having sex before the age of 15 declined and condom use increased between 2000 and 2005 in 9 of 13 sub-Saharan countries studied;

(h) Stigma and discrimination are key barriers to HIV prevention, treatment and support programmes. Stigma is an especially serious obstacle to the success of HIV prevention programmes, including services for vulnerable populations and for preventing mother-to-child transmission. According to over 30 civil society reports, stigma and discrimination against people living with HIV are pervasive. Women typically experience the most severe stigma and discrimination;

(i) The AIDS response is insufficiently grounded in the promotion, protection and fulfilment of human rights. Half of the countries submitting reports to UNAIDS noted the existence of policies that interfere with the accessibility and effectiveness of HIV-related measures for stigmatized populations. Legal systems in many countries also fail to provide adequate protection to children affected by HIV/AIDS and elderly caregivers. Even where legal protections exist, the capacity to put them into practice is often very weak;

(j) National Governments, international partners and communities are failing to adequately provide care and support for the 15 million children orphaned by AIDS and for millions of other children made vulnerable by the epidemic. Although most heavily affected countries in sub-Saharan Africa have national policy frameworks for children made vulnerable by AIDS, less than 1 in 10 of such children are reached by basic support services.

11. Key recommendations of the present report include:

(a) Governments:

- At the national level: Governments must lead and take greater accountability for the national response, allocating substantially greater resources themselves, actively promoting inclusion of all sectors of society and vigorously working to promote HIV awareness and alleviate stigma. All national programmes should have effective communication strategies to help raise awareness and reduce stigma. Health workers should be more vigorously involved in these efforts.

- At the international level: In addition to providing substantially to the financing of AIDS responses in many low-income countries, especially in sub-Saharan Africa, donors should work to ensure stability of funding through long-term financial commitments and permit flexibility in how the funds are spent to reflect evolving priorities. Adherence to the “three ones” principles and movement towards universal access are critical.

(b) Civil society: People living with HIV and other members of civil society, including faith-based organizations, business, labour and the private sector, must be equal partners in the development, implementation and monitoring of the national response. Governments and donors should prioritize initiatives to build and sustain the capacity of community organizations and networks of people living with HIV to respond to the epidemic.

(c) United Nations system: The United Nations system must fully leverage its unique potential to support countries in implementing and expanding effective national responses. The United Nations must be more accountable for its own activities as well as taking bolder actions to promote the fulfilment by countries and donors of their pledges and commitments. It also must perform better with strategic country coordination of the diverse multilateral partners, particularly through the establishment of joint country AIDS teams.

III. Five years after the Declaration of Commitment: a progress report

12. In the five years since the endorsement by the General Assembly of the Declaration of Commitment on HIV/AIDS, more than 20 million people have become infected with HIV, including roughly 3 million infants who contracted HIV during gestation or birth or as a result of breastfeeding. Since 2001, the epidemic has continued to expand in all regions, although it has begun to stabilize at extraordinarily high levels in some African countries. In recent years, the burden of the epidemic on women has increased notably, with women now representing half of all people living with HIV and nearly 60 per cent of all infections in Africa. Among young people in Africa, women constitute a staggering 77 per cent of new HIV infections.[3]

13. Envisioning a response that is truly comprehensive, the Declaration of Commitment on HIV/AIDS sets out time-bound targets for HIV prevention measures, care and treatment of people living with HIV, support for children affected by HIV/AIDS and interventions to mitigate the impact of the epidemic on households, communities and key sectors of society. The Declaration of Commitment envisions a global response to AIDS that is grounded in human rights and gender equality, as well as recognition of the factors that increase vulnerability to HIV.

14. In the past five years, the world has recorded major progress in some key aspects of the global AIDS response, but with inadequate progress on other critical fronts. In general, the strengthened global response, while heartening, is nevertheless being rapidly outpaced by the epidemic itself.

Leadership

15. The Declaration of Commitment provides that all countries will develop and implement sound national multisectoral AIDS strategies, integrate their HIV response into the mainstream of development planning and ensure the full and active participation of civil society, the business community and the private sector.

16. Almost 90 per cent of countries report having in place a multisectoral strategic framework to guide the national AIDS response, and 81 per cent have a national

HIV coordinating body. While almost 80 per cent of countries with national strategies report having mainstreamed AIDS in standard development instruments, only 56 per cent of the 32 countries with high HIV prevalence have evaluated the impact of the epidemic on national economic development. In many countries, multisectoral plans have yet to be converted into broad-based action, with programme implementation and budgetary allocations for AIDS often still heavily concentrated in the health sector.

17. In most countries, civil society groups surveyed by UNAIDS say the national Government has made progress in increasing the engagement of non-governmental sectors in the development, implementation and oversight of the national HIV response. In several countries in Africa, Asia and Europe, however, civil society actors say they have not been adequately involved in the national response. Civil society engagement is greatest with respect to HIV planning and budgeting, but less apparent in the monitoring of national efforts and virtually absent in the review of national strategies in one third of countries. In roughly one in four countries, services delivered by civil society groups are not integrated into the national HIV coordination mechanism. In many countries faith-based organizations are responsible for a large share of health care and education but are often not included or consulted when national plans and strategies are made.

18. Although the number of private companies expecting AIDS to have an impact on their business in the next five years increased from 37 per cent to 46 per cent between 2004/05 and 2005/06, only 6 per cent of private firms worldwide have a written HIV policy. In countries where HIV prevalence exceeds 20 per cent, a majority of companies (58 per cent) have written policies. While it is encouraging that HIV action by the business sector primarily focuses on HIV prevention, it is lamentable that fewer firms are making provisions for the delivery of antiretroviral drugs, especially where public sector services do not exist or cannot fully meet the need.

19. Key regional political bodies throughout the world have prioritized efforts to improve regional commitment and coordination on AIDS. At the global level, AIDS has remained near the top of the global political agenda. In both the 2005 World Summit Outcome (resolution 60/1) and the Gleneagles Communiqué of the Group of Eight industrialized countries, world leaders formally embraced the goal of getting close to universal access to HIV prevention, care and treatment. In its 2005 Doha Declaration, the Group of 77 and China called for enhanced South-South cooperation to implement prevention, treatment, care and support measures.

Prevention

20. Citing HIV prevention as the “mainstay of our response”, the General Assembly, in its Declaration of Commitment on HIV/AIDS, called for a 25 per cent reduction in HIV prevalence among young people (aged 15-24) in the most affected countries by 2005, as well as a 20 per cent reduction in the proportion of infants infected with HIV. According to the Declaration, 90 per cent of all young people (aged 15-24) were to have access to vital HIV prevention information, education and services, including life skills education, in 2005.

21. Since the 2001 special session, progress has been made globally in HIV prevention. Efforts to provide HIV prevention education for young people have achieved the following results:

(a) Eighty-five per cent of countries (78 reporting) have a policy or national HIV/AIDS strategy in place to promote HIV-related sexual health education for young people. The remaining challenge is to ensure effective implementation of educational programmes that are tailored to the needs of young people and offered in a manner that motivates young people to reduce their risk of infection;

(b) Eight-one per cent of countries (58 reporting) include AIDS education in the secondary school curriculum, with 74 per cent providing AIDS education as part of the primary school curriculum. The percentage of schools where trained teachers actually delivered AIDS educational sessions in the past year varies widely among reporting countries (from 3 per cent to 100 per cent). Among the 21 countries having comprehensive coverage data, only 9 reported having delivered AIDS education to more than 50 per cent of young people in 2005;

(c) Young peoples' knowledge of HIV remains inadequate. Available information indicates that the world is falling short of the aim of reaching 90 per cent of young people with accurate HIV-related information. In 18 countries (14 in sub-Saharan Africa and 1 each from Asia, Eastern Europe, Latin America and North Africa) in which young people (aged 15-24) were surveyed between 2001 and 2005, fewer than 50 per cent had an accurate understanding of HIV, with young men having a higher level of knowledge than young women in all but one country;

(d) On a more encouraging note, the percentage of young people having sex before age 15 declined between 2000 and 2005 in 9 of 13 sub-Saharan countries for which such information was available;

(e) Little or no change has been observed in the frequency of sexual activity with casual or non-marital partners over the past year. The percentage of young women and men reporting sex with a casual partner over the past year varies tremendously by country, region and gender;

(f) Condom use among sexually active 15- to 24-year-olds appears to have increased according to information provided by 11 countries in sub-Saharan Africa. Notable exceptions were Rwanda and Uganda, where condom use by young men actually decreased. As in other aspects of young people's sexual behaviour, there is tremendous variation in rates of condom use by country, region and gender;

(g) Counselling and testing to provide individuals with critical information on their HIV status is improving. In more than 70 countries surveyed, access to testing and counselling services, both voluntary counselling and testing and routine offers of testing within and outside health facilities, has quadrupled in the past five years, from over 4 million in 2001 to 16.5 million in 2005;

(h) HIV prevalence is perhaps the most telling sign of global progress in HIV prevention. UNAIDS is undertaking additional data collection and analysis to determine whether the world has satisfied the Declaration's 2005 target of reducing HIV prevalence by 25 per cent among young people in the most affected countries. Among 11 sub-Saharan African countries for which reliable epidemiological evidence is available for both 2000/01 and 2004/05, 6 reported a decline of 25 per cent or more among pregnant women (aged 15-24) living in capital cities.

22. Generally, however, HIV prevention efforts remain far too weak to slow the expansion of the epidemic. On average in 2005, a condom was used in only an estimated 9 per cent of risky sex acts globally. Access to condoms may be one

limiting factor. The United Nations Population Fund estimates that the gap between supply and demand for condoms in 2005 was 8 to 10 billion, or roughly 50 per cent. While condom use increased among young people in most sub-Saharan African countries surveyed, the overall frequency of condom use remains below 50 per cent in most countries, with fewer females than males reporting condom use during intercourse with a non-regular partner.

23. Compared to antiretroviral treatment coverage, which increased threefold between 2003 and 2005, the percentage of pregnant women offered HIV prevention services increased from 8 per cent to 9 per cent in 2005. The overall percentage of HIV-infected pregnant women actually receiving antiretroviral prophylaxis increased from 3 per cent to 9 per cent in the same period. Due to the absence of prevention services, 1,800 infants become infected with HIV each day. As with other HIV prevention services, there is striking variation in coverage among countries, with Botswana, for example, reaching at least 50 per cent of all HIV-infected pregnant women with prevention services.

24. Numerous factors hinder the implementation of proven prevention measures. First and foremost, the enduring stigma associated with HIV and with the behaviours that facilitate HIV transmission often discourages national decision makers from pursuing sound public health policies while also deterring individuals at risk from learning their HIV serostatus or accessing prevention information and services. In addition, the low status accorded women in many countries renders them highly dependent on relationships that put them at risk of HIV infection. In many parts of the world, married women cannot abstain from sex, insist that their husband use a condom during sexual intercourse or demand their husband's fidelity. Human trafficking and cultural practices such as genital cutting also increase the vulnerability of many women to HIV infection.

25. With the aim of reinvigorating the global AIDS prevention effort, the UNAIDS Programme Coordinating Board endorsed a new global AIDS prevention policy in 2005 set out in a paper entitled "Intensifying HIV prevention". The paper identifies specific programmatic and policy actions that all countries should adopt as part of their national HIV prevention strategies. It recognizes that effective HIV prevention requires not only the delivery of programmes and technologies to reduce risk but also broader social and cultural changes to reduce vulnerability. To be effective, HIV prevention efforts must be grounded in what we know works; achieve sufficient coverage, scale and intensity; be sustained over time; include the views and priorities of young people themselves; and move beyond the health sector, involving diverse sectors of society.

Care, support and treatment

26. Recognizing that care, support and treatment are fundamental elements of an effective response, the Declaration of Commitment on HIV/AIDS provides that countries will implement national treatment strategies and increase access to comprehensive care. In July 2002, the World Health Organization (WHO) and UNAIDS unveiled the "3 by 5" initiative, which was launched in December 2003. It had as its goal placing 3 million people in developing countries on antiretroviral drugs by the end of 2005. Although the initiative fell short of its target, it galvanized global efforts to deliver life-preserving treatments in resource-limited settings,

engaging all national Governments, leading donors, multilateral agencies, private industry and civil society.

27. Since the “3 by 5” initiative was launched in 2003, the number of people on antiretroviral drugs in low- and middle-income countries more than tripled, to 1.3 million. The number of people receiving antiretrovirals in sub-Saharan Africa increased eightfold over the two-year period covered by the initiative. Twenty-four countries achieved the target of providing treatment to at least half of those in need. The initiative definitively demonstrated that administration of antiretroviral drugs is feasible in resource-limited settings, that rates of treatment adherence in developing countries are as good or better than those reported in high-income countries and that a streamlined public health approach helps to expedite the introduction of complex therapies. As a result of increased treatment access, between 250,000 and 350,000 deaths were averted worldwide in 2005.

28. AIDS treatment sites are ideal venues for the delivery and reinforcement of HIV prevention, and emerging evidence indicates that prevention programmes specifically designed for people living with HIV are effective in reducing the incidence of risky behaviour.

29. As at December 2005, the Global Fund to Fight AIDS, Tuberculosis and Malaria was supporting the delivery of antiretroviral therapy to 384,000 people, and the United States President’s Emergency Plan for AIDS Relief has exceeded its projected pace of treatment scale-up, providing antiretroviral drugs to more than 400,000 people as at December 2005.

30. In addition to its multi-country AIDS programme, the World Bank launched a $60 million treatment acceleration project in 2004/05, with initial grants for expedited treatment scale-up provided to Burkina Faso, Ghana and Mozambique. The private sector is also contributing to treatment scale-up, delivering antiretroviral drugs to 60,000 people in South Africa alone. Faith-based organizations provide the majority of antiretrovirals in several countries. WHO has played a central role in helping countries to implement and expand antiretroviral treatment programmes through the pre-qualification of drugs, the provision of information on pricing, linking of AIDS treatment programmes to other health initiatives and implementation of a global surveillance system to monitor antiretroviral drug resistance.

31. To date, evidence has failed to detect significant gender inequities in access to antiretroviral drugs, although experience indicates that women often confront unique obstacles to treatment adherence. Some populations clearly are not adequately reaping the benefits of increased treatment access. In Eastern Europe and Central Asia, where injecting drug users account for more than 70 per cent of all people living with HIV, they make up less than 25 per cent of people on antiretroviral therapy.

32. Children have also not benefited appreciably so far. Diagnosing HIV in children is frequently complicated in resource-limited settings, and the optimal time to initiate treatment is often not apparent. Moreover, there are few formulations of antiretroviral drugs suitable for use in children, and those that are available tend to be much more expensive than adult regimens. In October 2005, the Secretary-General, with the United Nations Children’s Fund, UNAIDS and others, launched “Unite for children, unite against AIDS”, a child-focused global campaign that aims

in part to improve access to paediatric AIDS treatment. While major challenges exist, there is reason for optimism that the availability and affordability of paediatric formulations and much-needed diagnostics for infants and children will increase in the near future.

33. Comprehensive AIDS treatment and care involves more than antiretrovirals, encompassing the treatment of opportunistic infections, proper food and nutrition, psychosocial care and other essential health and social services. In many countries, treatments for common opportunistic infections are frequently unavailable. Individuals co-infected with HIV and tuberculosis often find it difficult to access a comprehensive health service package that addresses the needs of both diseases. Cotrimoxazole, a drug that costs as little as $0.03 a day to prevent life-threatening opportunistic infections, is currently not available to an estimated 4 million children who need it.

34. To scale up towards universal access, workable strategies are needed to overcome obstacles that have thus far slowed the pace of treatment scale-up. For example, far too few people at risk of infection currently know their HIV serostatus, leading several countries to undertake new strategies to promote HIV counselling and testing, including the routine offer of an HIV test to patients in health-care settings and door-to-door visits from public health workers to increase the utilization of rapid testing.

Human rights, stigma and discrimination

35. The Declaration of Commitment on HIV/AIDS emphasizes the centrality of human rights and fundamental freedoms in an effective AIDS response. The Declaration calls upon countries to enact legislation barring discrimination against people living with HIV and against vulnerable and at-risk populations. By 2005 countries should have developed national strategies to promote the advancement of women, ensure services for women and girls to protect themselves against HIV and eliminate all forms of discrimination against them. Most countries (82 per cent) have a policy in place to ensure equal access, between men and women, to prevention and care. In reality, however, social, legal and economic factors impede women's ready access to vital services.

36. Between 2003 and 2005, there appears to have been some improvement in the integration of a human rights approach in national HIV efforts, although human rights protections remain far too weak and fragmented to support a comprehensive and optimally effective HIV response. In 16 of 18 countries surveyed from sub-Saharan Africa, the Asia-Pacific region, Eastern and Western Europe and North Africa, national reports cited improvement in policies, laws and regulations in place to promote and protect human rights. Several reports indicate, however, that many such national laws have not been implemented or rigorously enforced, often because of a lack of adequate budget allocations for human rights monitoring.

37. Almost half of countries submitting data to UNAIDS report the existence of laws that may hinder the delivery of HIV prevention and treatment services to vulnerable and at-risk populations. Examples include the criminalization of consensual sexual contact among adults of the same gender, legal impediments to syringe exchange or substitution therapy and use of residency status to restrict access to services.

Reducing vulnerability

38. Recognizing that poverty, social marginalization and discrimination create conditions that increase vulnerability to HIV, the Declaration of Commitment on HIV/AIDS provides that countries will implement national policies and programmes to promote and protect the health of populations at greatest risk of HIV infection. Both independent surveys and information supplied to UNAIDS by low- and middle-income countries themselves indicate that national efforts are not sufficiently prioritizing the delivery of essential, life-preserving interventions to those at greatest risk.

39. According to multiple service coverage surveys, targeted, community-based HIV prevention services reached only 36 per cent of sex workers, with coverage ranging from 8 per cent in Eastern Europe and Central Asia to 39 per cent in South-East Asia. Community-based prevention programmes reached on average only 9 per cent of men who have sex with men, ranging from 1 per cent in Eastern Europe and Central Asia to 22 per cent in Latin America and the Caribbean.

40. The world's 9 million refugees and 25 million internally displaced persons are often highly vulnerable to HIV and other health threats but frequently suffer from the disruption of support networks and service systems caused by conflict and other humanitarian emergencies. The Office of the United Nations High Commissioner for Refugees and its partners are providing voluntary testing and counselling in more than 30 refugee camps in 11 countries, as well as services to prevent mother-to-child transmission in at least 20 refugee camps in 6 countries. A total of 86 per cent of countries have in place an AIDS strategy for uniformed services, up from 78 per cent in 2003.

Children orphaned and made vulnerable by HIV/AIDS

41. Data from high-prevalence countries indicate some progress in the development of child-focused policy frameworks on AIDS but substantially less success in delivering essential services to children orphaned or made vulnerable by AIDS. Among 26 countries in sub-Saharan Africa, 22 report that they have national policies in place to address the additional HIV and AIDS-related needs of orphans and other vulnerable children, although country reports, on average, rate the level of national commitment to these vulnerable children as 5 or below on a scale of 1 to 10. Among the 18 countries with national policies, 14 report having reduced or eliminated school fees for AIDS-affected children and having implemented community-based programmes to support orphans and other vulnerable children. Countries are increasingly opting for strategies that aim to address the needs of all vulnerable children, as targeting children living with HIV for special services may be stigmatizing and therefore counterproductive.

42. Although there has been some improvement in rates of school attendance, orphans (aged 10-14) continue to lag behind non-orphans. In sub-Saharan Africa, 70 per cent of non-orphaned children who live with at least one parent currently attend school, in comparison with 62 per cent of children who have lost both parents. Only 19.5 per cent of street children are being reached by outreach services. Overall, the limited data available indicate that fewer than 10 per cent of households supporting children orphaned or made vulnerable by AIDS are reached by community-based or public sector support programmes.

Research and development

43. In the past five years, important progress has been made in research on and development of new HIV-prevention methods. In 2005, a clinical trial in South Africa found that adult male circumcision reduced the risk of sexual infection to men by 60 per cent over the 18-month study period. Two other large-scale trials of adult male circumcision are under way to confirm the South Africa results, to identify optimal circumcision methods and to test whether circumcision might also offer a degree of protection to women.

44. Development of an effective microbicide would significantly strengthen HIV prevention efforts by offering women an unobtrusive prevention method that is under their control. The number of microbicide candidates in some stage of active development increased from 10 in 2001 to more than 20 in 2005, including five candidates currently in late-stage clinical trials. Public and philanthropic spending on research on and development of microbicides increased from $65.4 million in 2001 to an estimated $163.4 million in 2005.

45. Progress in the search for a vaccine has been slow, and leading scientists project that it is likely to be a decade or more before a preventive vaccine is available for widespread use. The Global HIV Vaccine Enterprise, an alliance of independent entities dedicated to enhanced collaboration on AIDS vaccines, published in 2005 a strategic scientific plan that is intended to guide the actions and resource allocations of key actors in the field. Public and philanthropic expenditures on HIV vaccine research and development increased from $366 in 2001 to $627 million in 2005.

Resources

46. Ten years ago, when UNAIDS became operational, the world spent less than $300 million on HIV programmes. The Declaration of Commitment on HIV/AIDS called for a steady scaling-up of global HIV financing to ensure the annual mobilization by 2005 of at least $7 billion, to $10 billion.

47. In the past five years, the world has mobilized unparalleled resources for the global HIV response, achieving the financing target in the Declaration of Commitment by making an estimated $8.3 billion available for HIV programmes in 2005. The pace of increase in HIV resources has accelerated since the special session, with an average annual increase in resources of $1.7 billion between 2001 and 2004 compared with an average annual increase of $266 million between 1996 and 2001.

48. Among 25 countries in sub-Saharan Africa, domestic public sector outlays on AIDS increased by 130 per cent since the special session, reaching a total allocation of $640 million in 2005. Despite this increase, per capita AIDS spending remained low in those countries (roughly $0.65). The increase among middle-income countries outside sub-Saharan Africa in the same period was around 10 per cent and averaged $2.20 per capita in 2005, thus showing the potential of those countries to contribute a significant share of the AIDS budget from their own governmental sources.

49. The United States of America accounts for roughly half of all bilateral spending on HIV. Consistent with the provisions of the Declaration of Commitment, the Global Fund to Fight AIDS, Tuberculosis and Malaria was launched in

December 2001 and has rapidly become an important vehicle for mobilizing new resources for HIV. As at December 2005, the Global Fund had received $4.8 billion in actual contributions. Current grant agreements provide for approximately $2 billion in financing for AIDS programmes, including $1.2 billion that has already been disbursed. The World Bank has remained a key source of multilateral financing, having committed more than $2.5 billion to the end of 2005.

50. Substantially greater resources will be required in the future to place the world on track to reverse the epidemic by 2015 — $18.1 billion in 2007 and $22.1 billion in 2008. Unfortunately, the rate of increase in HIV funding appears to be slowing, underscoring the need to redouble leadership and commitment on HIV to generate the level of resources required to finance an effective response.

Monitoring and evaluation

51. The mandate in the Declaration of Commitment for periodic reporting on progress underscores the importance of strong national systems for monitoring and evaluation. Although 51 per cent of reporting countries say national monitoring and evaluation improved between 2003 and 2005, nearly half (43 per cent) rate such efforts as average or below average. Half of the reporting countries have a national plan for monitoring and evaluation, with 33 per cent in the process of developing such a plan. Most countries are currently unable to disaggregate utilization data by gender or other demographic variables, preventing the accurate and timely monitoring needed to ensure equitable access.

IV. To 2010 and 2015: reversing the epidemic through an extraordinary response

52. The world is at a defining moment in its response to the AIDS crisis. Although the epidemic and its toll continue to outstrip the worst predictions, the foundation for an extraordinarily stronger and sustained response is largely in place. For the first time ever, the will and means needed to make real headway have been secured.

53. The AIDS response, however, cannot end in 2010, with the final milestones of the Declaration of Commitment, or in 2015, when the Millennium Development Goals expire. Rather, AIDS will demand exceptional global mobilization for at least the next generation. Each intervention, plan and programme established today must become the building block for sustainable, longer-term strategies to eventually free the world of AIDS.

Scaling up towards universal access

54. At the 2005 World Summit, world leaders committed to a massive scaling up of comprehensive HIV prevention, treatment and care services with the aim of coming as close as possible to the goal of universal access to treatment by 2010 for all who need it. The General Assembly then tasked UNAIDS with facilitating inclusive, country-led processes to develop strategies to move towards universal access. More than 100 country consultations and 7 regional consultations have so far been held. A global steering committee was convened to examine obstacles and potential solutions to be implemented at the international and country levels.

UNAIDS is submitting to the Assembly at its current session an assessment of the process to date, including the key obstacles to scaling up and recommendations for overcoming them (see A/60/737).

55. Accelerating the pace of implementation requires that all actors in the AIDS response embrace more efficient and better-coordinated approaches, guided by the "three ones" principle. As both the global response and the number of actors involved have expanded, the need for coordination and harmonization has become ever more pressing. All actors in the global response must commit to using every bit of available financing as efficiently and effectively as possible. Fragmentation, waste and duplication must be replaced by strategic focus, accountability and collaboration.

Strengthening capacity

56. Lack of human and institutional capacity is the single biggest obstacle to an effective response to AIDS in many developing countries, particularly in the most heavily affected countries, where the epidemic itself has dramatically undermined national resources. Addressing these capacity barriers is a precondition to making essential HIV services widely available. Because the poor principally rely on public services, strengthening public sector capacity is an overriding imperative in the global AIDS response.

57. Countries should actively explore innovative ways of extending existing resources as far as possible, including such avenues as mentoring programmes, strategic partnerships and staff exchange programmes between institutions, and the sharing of technical expertise and experience with other countries. Donors should prioritize measures to build and sustain national capacity, helping countries to upgrade pay scales to prevent the loss of essential personnel and aiding countries in expanding the roles of all levels of health workers, household members, mid-level providers and community workers and people living with HIV.

Accelerating technological innovation and ensuring equitable access

58. Continued technological innovation is vital for the development of microbicides and other female-controlled prevention methods, new generations of drugs, and a preventive vaccine. Challenges ahead include the mobilization of substantially greater research financing, especially from the pharmaceutical and biomedical industries, and rekindling and sustaining passion among AIDS researchers to continue the drive towards effective vaccines, microbicides and, ultimately, a cure for HIV infection. While the world energetically pursues a stronger, better-financed research agenda, the systems and agreements that will guarantee wide and equitable access into the future need to be put in place. Governments should actively work with their national pharmaceutical industries and other stakeholders to reduce the price of medications and technologies for developing countries. They should also support operational research to inform and accelerate scale-up in countries.

Addressing the fundamental drivers of the epidemic

59. In addition to scaling up prevention and treatment programmes, long-term success on AIDS requires that the global community address the factors that increase vulnerability to HIV, such as poverty, illiteracy, economic and gender inequality and all forms of discrimination and social exclusion. To help reverse the epidemic, high priority should be given to poverty-reduction strategies, girls' education, women's economic opportunities and other basic reforms.

New ways of working

60. To generate the exceptional response demanded by this most exceptional global crisis, all actors in the global AIDS response must embrace new ways of doing business and new ways of working together.

An agenda of action for Governments

61. *Domestic AIDS agenda*. Countries must confront stigma and discrimination with active, well-funded communications programmes. With leadership from the national Government, all country-level stakeholders should agree on country-specific targets towards universal access and reach a consensus on a limited set of core indicators to measure progress. Countries should place priority on building sufficient monitoring and evaluation capacity to increase the transparency and accountability of the national response and to inform future decisions on national policies and programmes. Governments should increase their own investments in HIV programmes, and middle-income countries in particular must do their fair share of financing a strong national response.

62. *International AIDS agenda.* While developing countries, especially middle-income countries, should do more to finance the response to HIV, the world must look primarily to international donors to close the looming resource gap. Just as the launching by the United States Government of the President's Emergency Plan for AIDS Relief initiative and the birth of the Global Fund to Fight AIDS, Tuberculosis and Malaria helped to galvanize greater commitment of resources, donors must energetically move to place HIV funding levels on a higher plane to support a response capable of reversing the epidemic. In the quest to mobilize unprecedented sums for HIV programmes, all donors must do their part and avoid leaving the lion's share of financing to a small handful of donor countries.

63. To increase the certainty and sustainability of financing, donors should make multi-year financing commitments for HIV programmes. Donors must work to translate the "three ones" from aspiration to reality by aligning their assistance with nationally led strategies and by actively supporting unitary national systems for monitoring and evaluation. In ramping up HIV support, donors should prioritize measures to build and sustain national capacity, helping countries to upgrade pay scales to prevent the loss of essential personnel and aiding countries in expanding the roles of all levels of health workers, household members, mid-level providers, community workers and people living with HIV.

64. The high cost of second- and third-line antiretroviral regimens threatens the long-term viability of treatment scale-up. Donors should actively work with their

national pharmaceutical industries and other stakeholders to reduce the price of such medications for use in developing countries.

An agenda of action for civil society

65. In all countries, civil society must be an active participant in the development, implementation and evaluation of national and subnational HIV strategies. National HIV plans and coordinating bodies should take account of services delivered by community-based groups, and national budgets and donor assistance should include the provision of extensive capacity-building assistance to civil society organizations and networks. Provided with adequate resources, civil society can play a major role in monitoring the implementation and effectiveness of national efforts, including national success in achieving the time-bound targets of the Declaration of Commitment and agreed milestones along the road to universal access.

66. In many countries, networks of people living with HIV have played a critical role in reducing stigma, encouraging people to learn their HIV serostatus, promoting treatment awareness and literacy and building national commitment, but such organizations often lack needed capacity. At this stage of the global response, the challenge is to move beyond the tokenistic "involvement" of people living with HIV to ensure their active and meaningful participation in AIDS efforts. Faith-based organizations are also vital partners in the AIDS response and should seek out collaboration with Governments, AIDS service organizations, groups of people living with HIV and other actors.

An agenda of action for the United Nations

67. For the United Nations system, HIV poses a pre-eminent challenge. Consistent with the principles of reform, the United Nations joined with donors and other stakeholders 10 years ago to create the Joint United Nations Programme on HIV/AIDS, which unites under a single biennial budget and workplan the efforts of 10 United Nations co-sponsor agencies and a Geneva-based secretariat. The last two UNAIDS unified budgets and workplans have strongly emphasized improved coordination and coherence at the country level and enhanced technical support, including the creation of regional technical support networks to support rapid programme implementation and scale-up. In December 2005, the Secretary-General directed all United Nations country offices to create a new structure, a joint United Nations country team on AIDS, to focus on day-to-day operational issues to promote a single joint programme of support.

68. The United Nations has taken on the challenge of addressing HIV in its own workplace. In line with its reform effort, the United Nations system has endorsed a strategy to move towards a joint workplace programme on HIV/AIDS, "UN cares", based on the International Labour Organization code of practice on HIV/AIDS and the world of work. United Nations staff living with HIV have formed an informal group to give voice to the issues affecting those living with HIV and working within the United Nations system.

69. In March 2005, a global task team, comprising more than 55 Governments and organizations and facilitated by UNAIDS, launched an urgent 80-day process to develop recommendations to improve coordination in the multilateral system and to streamline, simplify and further harmonize multilateral action on HIV, with the aim of promoting strong country-led responses and reducing national burdens associated

with external aid. The global task team recommended implementation by the United Nations system and the Global Fund of a common problem-solving mechanism to assist countries in overcoming bottlenecks and obstacles to scale-up, clarification of the division of labour among multilateral institutions for the provision of technical support and enhanced financing for technical assistance.

70. The United Nations is contributing to the success of the Global Fund by helping scores of countries to develop evidence-based funding proposals. Responding to the shortage of technical resources, UNAIDS is in the process of establishing regional technical clearing houses throughout the world. Normative guidance and technical support by WHO is accelerating treatment scale-up by enabling countries to implement simplified treatment protocols for a public health approach to antiretroviral therapy. In moving forward, the United Nations should build on these encouraging successes by bringing its unique value to bear in contributing to the scaling-up of AIDS programmes worldwide.

V. Conclusion

71. **The 2001 special session of the General Assembly on HIV/AIDS will endure as a landmark in the world's efforts against the AIDS crisis. World leaders drew public attention to the exceptional challenge to human life and dignity posed by the global AIDS epidemic and, in their Declaration of Commitment on HIV/AIDS, unanimously committed to mounting an exceptional response. As a result, significant progress has been made at every level of the response. The comprehensive review of the Declaration and high-level meeting to be held from 31 May to 2 June 2006 is a critical opportunity for world leaders to chart a way forward so that the goals and vision of the Declaration are achieved in their entirety and so that an exceptional response is sustained into the future. This leadership commitment is the key to ultimately putting an end to AIDS.**

Notes

[1] United Nations publication, Sales No.05.III.B.1.

[2] "The global impact of scaling up HIV/AIDS prevention programs in low- and middle-income countries", Stover J., Bertozzi S., Gutierrez J. P., Walker N., Stanecki K. A., Greener R., Gouws E., Hankins C., Garnett G. P., Salomon J., Boerma J. T., De Lay P., Ghys P. D., *Science Express*, vol. 311, No. 5766, 2 February 2006.

[3] The Global Coalition of Women against AIDS, the Association of First Ladies of Africa and the Global Business Coalition all seek to reduce vulnerability and improved access to prevention, treatment and care services.