**TECHNICAL BACKGROUND NOTE on the DRAFT DECLARATION OF COMMITMENT**

**(Submitted by the UNAIDS Secretariat at the request of the UNGASS facilitators)**
**09/05/2001**

## Preamble

### *Framework for Global Leadership on HIV/AIDS*

The development of the Framework for Global Leadership on HIV/AIDS started in 1998. The process involved consultations among UN agencies, national governments and bilateral partners in every region. Several regional consultations with non-governmental organizations, including religious institutions, were also held. The Framework for Global Leadership on HIV/AIDS provides the rationale for the urgent mobilization of an expanded global response to the epidemic, which simultaneously addresses HIV/AIDS-related risk, vulnerability, and impact. The Framework for Global Leadership on HIV/AIDS promotes a set of guiding principles and Leadership Commitments to which key actors at global, national and community levels have been encouraged to subscribe. The Leadership Commitments provide a common basis for the many actors engaged in the response to focus on urgent priorities and harmonize their strategies with one another to assure greater synergy in the response.

In December 2000, the UNAIDS Programme Coordinating Board (PCB), comprised of Member State, NGO and UN system representatives:

- **endorsed** the Framework for Global Leadership on HIV/AIDS ***affirming*** *that its guiding principles, expanded response approach and leadership commitments are universally applicable and should be rapidly translated into action at country level.*

- ***encouraged*** *Member States to make use of the Framework to elaborate common goals and formulate specific commitments at the highest levels, including in their role as Members of the United Nations General Assembly Special Session (UNGASS) on HIV/AIDS and as representatives on the governing bodies of cosponsoring organizations.*

- ***recommended*** *that UNAIDS ensure widespread dissemination of the Framework in a number of languages and encourage its use to guide the further development of strategic processes within regions, priority sectors, and thematic areas in support of country efforts.*

## Leadership

### *UN System Strategic Plan for HIV/AIDS*

The UN System Strategic Plan for HIV/AIDS (UNSSP) guides the UN system response to HIV/AIDS over a five-year period. The current one covers the period 2001-2005.. It identifies the key functions of the UN system in support of national efforts, and describes the approach and priorities of the participating UN system organizations in a coordinated UN system response. The UNSSP has been developed within the overall framework of the Framework for Global Leadership; in particular the Leadership Commitments have been used to structure the

actions of the UN system into operational Areas of Work. The goals and targets of the UNGASS will serve as the primary focus for UN system, as well as national efforts, during the plan period.

The strategic objectives for the UN system articulated in the UNSSP link the work of individual UN agencies to the overarching UN system objective of providing leadership and adding value to the work of national governments and other partners in achieving agreed goals. The Interagency Advisory Group on AIDS (IAAG) served as a forum through which the outline and process of the UNSSP was finalized, and twenty-nine UN system organizations have contributed to the Plan through the development of individual agency plans and strategies. These agencies have made a major commitment to increasing their investments, effectiveness and accountability over the plan period.

## Prevention

### *Internationally-agreed goal on young people*

There is only one internationally agreed prevention goal for HIV/AIDS in young people. This goal was adopted at the 21st Special Session of the United Nations General Assembly in July 1999 and reads as follows:

*"Governments, with assistance from UNAIDS and donors, should, by 2005, ensure that at least 90 per cent, and by 2010 at least 95 per cent, of young men and women aged 15 to 24 have access to the information, education and services necessary to develop the life skills required to reduce their vulnerability to HIV infection. Services should include access to preventive methods, such as female and male condoms, voluntary testing, counseling and follow-up. Governments should use, as a benchmark indicator, HIV infection rates in persons 15 to 24 years of age, with the goal of ensuring that by 2005 prevalence in this age group is reduced globally, and by 25 per cent in the most affected countries, and that by 2010 prevalence in this age group is reduced globally by 25 per cent."*

For the purposes of the UNGASS on HIV/AIDS, we have focused on the most critical elements, which are: reducing prevalence in young men and women aged 15 to 24 by 25% in the most affected countries by 2005, and globally by 2010.

While committed national programmes do achieve reductions in the rate of new infections in all parts of the population, and thus eventually prevalence, such reductions are first seen, and most pronounced, in the youngest age groups. Studies in some countries and sub-regions have actually shown reductions in HIV prevalence in 15-24 year old pregnant women of 25% or more within a 5-year period. However, as many countries are still in the early phases of the epidemic, with increasing numbers of new infections and prevalence rates, it will be very difficult for such countries to achieve this goal by 2005. Epidemiological models show that a reduction by 25% in the worst affected countries, that have already more developed epidemics, will be possible, if effective programmes will be put in place immediately. Globally, this goal is achievable by 2010.

The challenges to achieving the international goals and targets addressing the protection of children and young people from HIV/AIDS are considerable. Half of the new HIV infections that occur each year are in young people under the age of 24. While cultures throughout the world are appropriately protective of their children, good intent often extends to unsafe practice in the form of reluctance to discuss and share information about sexuality or drug use. As a

consequence, only about half of 15-19 year olds globally know how to protect themselves from HIV infection, and in sub-Saharan Africa, less than half of in-school and less than a quarter of out-of-school 12-16 year olds receive HIV education. Parents, educators and community leaders often lack the information and skills they require to effectively communicate with young people about such inherently sensitive issues. Access to essential prevention information and services is limited by policy and social constraints in schools and the media, and exacerbated by low school enrolment rates among adolescents.

Political constituencies for young people are weak and their participation in decision-making limited. Their social protection and employment needs receive low priority within public sector budgets, leaving young people with little or no purchasing power with respect to essential services and commodities. Consequently, many young people who know how to protect themselves from infection are not empowered to do so. Where policymakers are willing to make children and young people a priority, they often lack relevant examples of successful policies and programmes for advocacy, and resources for implementation. With service mandates for children, young people, and pregnant women divided among multiple ministries and departments and receiving low overall investments, there is often weak infrastructure on which to build relevant HIV/AIDS service delivery for children and young people. Infrastructure limitations are exacerbated in the absence of coherent strategies and effective coordination.

***Definition of "harm reduction"***

Harm reduction refers to policies and programmes aimed at reducing the adverse health, social and economic consequences of mood altering drugs. Harm reduction can include: (i) abstinence or reduction in consumption of drugs; (ii) prevention of transmission of HIV and other diseases among injecting drug users; and (iii) use of less harmful drugs in place of the more damaging ones.

Based on evidence from many countries around the world, harm reduction programmes have proven to be effective in preventing HIV infection among injecting drug users. Effective harm reduction programmes are not limited to the provision of sterile injecting equipment but must also include other components such as AIDS awareness raising and education among drug users and their sex partners, provision of barrier methods to prevent sexual transmission, drug dependence treatment and rehabilitation, treatment of sexually transmitted diseases and other health services; and access to voluntary and confidential counselling and testing. Moreover, local communities, including the drug-user community itself, must be mobilized and participate fully for such package of measures to work. No single element of this package will be fully effective if practised on its own.

Harm reduction programmes do not promote drug use and can be implemented in countries alongside programmes on primary prevention of drug use and demand reduction.

***Definition of "informal sector" and the importance of workplace prevention programmes***

The informal sector is characterized as an economic unit, mostly in urban areas, operating on a small-scale basis and aimed at generating employment and basic income (e.g., markets). According to ILO estimates, this sector has an employment share between 30 to 80%. In Asia, it absorbs between 40 to 50% of the urban labour force; in Africa, it employs about 61% and was estimated to have created about 90% of all jobs in the region in the last decade. This workforce typically lives in poor areas, lacks basic health services, does not enjoy social

protection benefits, and works in unhealthy environments. Women, adolescents and children comprise the large proportion, doing mostly manual, unskilled tasks. Due to low capitalization and high competitiveness, working conditions are greatly compromised, with any occupational health services barely available. The interactions between occupational hazards, poor living conditions, and poor working practices all combine to make this huge labour force extremely vulnerable to HIV transmission, as well as to other health hazards.

AIDS prevention and care within the informal sector poses a difficult challenge because it constitutes a hard-to-reach group of the population. Initiatives have usually not been at a scale commensurate to the size and characteristics of the target groups and resource constraints have hampered sustainability. In addition, such activities are often not mainstreamed into national AIDS programmes for various reasons, among them, reliance on the private sector for AIDS in the workplace programmes and priority to high risk groups. That women and young people are largely found in the informal sector makes it even more important that AIDS initiatives target this sector. Gender-related factors pose additional barriers, including lack of access to basic education, skills training, health services, work security, and justly remunerated work. In addition, these groups are vulnerable to sexual exploitation in the workplace, from which they have limited protection.

### *Explanation of mother to child transmission goal*

Mother to child transmission is the most significant source of HIV in children aged 0 to 15 years. In 2000 alone, about 600,000 new infections occurred, the vast majority from mothers who in the first place did not know their HIV serostatus. In the most affected countries, the risk of a baby acquiring HIV from an infected mother ranges from 25 to 35 %.

In determining the goal included in the Declaration of Commitment, the following elements were considered:

- prevalence of HIV in pregnant women;
- yearly incidence of HIV infections as a result of mother to child transmission;
- access and coverage of antenatal care services;
- access and coverage of mother to child transmission-specific interventions (voluntary counselling and testing, antiretroviral use, infant feeding alternatives) for women covered by antenatal care services;
- effectiveness of the interventions; and
- effectiveness of primary prevention of HIV infection in women of child bearing age.

The target is based on the following assumptions:

- by 2005, voluntary counselling and testing coverage (offer and acceptance) of 50% of all HIV positive pregnant women, or women at risk of HIV infection, who attend antenatal services; and 75% by 2010;

- by 2005, drug intervention (availability and acceptance) at a rate of 80% of pregnant women who tested positive; and close to 100% by 2010;

- by 2005, reduction in prevalence by 25% in young women in the worst affected countries, and globally by 2010.

Achievement of the target is based on the following strategies[1]:

- **prevention of HIV infection in girls and women of child-bearing age.** In addition to the general strategies to prevent HIV infection to achieve the ICPD+5 goal on reduction of infection in young people, strengthening of interventions focusing on reproductive health in young women is necessary;

- **prevention of unwanted pregnancies in HIV-positive women and women at risk for HIV infection**, through Voluntary Counselling and Testing of women and their partners in the context of family planning services; and

- **specific interventions to prevent mother to child transmission in HIV-positive pregnant women**. Studies have proven the effectiveness and feasibility of specific interventions to prevent mother to child transmission in different settings, including in the poorest countries. Some of the interventions are readily available and affordable today, even in resource poor settings. Treatment with nevirapine, for example, one of the recommended drugs to prevent mother to child transmission, costs only 4 US$ per pregnancy, can be obtained free of charge in developing countries and is easy to administer. A second element consists of the appropriate guidance and provision of safe infant feeding alternatives.

## Care, Support and Treatment

### *Definition of "technical and system capacity" related to the provision of drugs, and differential pricing"*

**Technical capacity** in a drug management system denotes the level of staff competence and physical infrastructure that exists in a given context to bring drugs to the point where they are dispensed to the client (i.e., the patient). This does not ensure, however, that the drugs are rationally used. For that, one needs competent prescribers to choose from the many drugs that could be used, and informed and motivated clients to take the drugs as prescribed. **Health system capacity** to use drugs, therefore, includes drug management (the work of the pharmaceutical sector), as well as action by other players (such as doctors and nurses).

**Differential pricing** – also referred to as "tiered pricing" or "preferential pricing" – refers to the concept that the prices of essential drugs and vital HIV medicines should reflect countries' abilities to pay as measured by their level of income. The goal of differential pricing is to help ensure that price is not a barrier to low income countries securing access to drugs for their populations.

### *Definition of types of care*

**Medical care** is the care given by doctors and nurses. It involves for the most part drugs and or surgery, and always formally qualified health professionals.

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[1] The achievement of the goal includes a number of general and specific mother to child transmission-related strategies. It is estimated that mother to child transmission through **mother to child transmission- specific** interventions for HIV -positive pregnant women alone can be reduced by 15% by 2005, and by 30% by 2010.

**Psychosocial care** is the care that deals with the psychological (i.e. personal) reactions to disease (anxiety, depression) and the social dimension of disease (unemployment, feeling useless because one's social role is dramatically altered because of disease, etc.). Psychosocial care is often provided by friends, family and community members, but as health systems develop, also by professionals (psychologists, social workers, even doctors and nurses).

**Palliative care** deals with symptoms - physical or psychological, that are 'palliated', i.e. suppressed or made less serious, without removal of the underlying condition. It has tended to focus on the terminal stages of a disease or condition, but clearly, palliation is needed at earlier stages too. It is partly given by formally qualified health care workers (and is thus in part an aspect of medical care), but also to a large extent also by family members and sometimes community organizations. When psychological symptoms are palliated, it is also part of psychosocial care.

All 3 types of care are important because they alleviate suffering and thus improve the quality of life of their clients and allow them to contribute longer and better to society. In addition, medical care and psychosocial care (suicide prevention) increase the life expectancy of their clients.

## HIV/AIDS and Human Rights

### *International Guidelines on HIV/AIDS and Human Rights*

- *The Secretary-General in his report to the UN Commission on Human rights called for the development of these Guidelines (E/CN.4/1995/45*, para. 135). He stated that "the development of such guidelines or principles could provide an international framework for discussion of human rights considerations at the national, regional and international levels in order to arrive at a more comprehensive understanding of the complex relationship between the public health rationale and the human rights rationale of HIV/AIDS. In particular, Governments could benefit from guidelines that outline clearly how human rights standards apply in the area of HIV/AIDS and indicate concrete and specific measures, both in terms of legislation and practice, that should be undertaken".

- *The Commission on Human Rights, in resolution 1996/43 of 19 April 1996,* requested the then United Nations High Commissioner for Human Rights, *inter alia*, to continue his efforts, in co-operation with UNAIDS and non-governmental organizations, as well as groups of people living with HIV/AIDS, towards the elaboration of guidelines on promoting and protecting respect for human rights in the context of HIV/AIDS. In the same resolution, the Commission requested that the Secretary-General prepare, for the consideration of the Commission a report on the above-mentioned guidelines, including the outcome of the second expert consultation on human rights and AIDS, and on their international dissemination.

- In response to the above requests, the Office of the United Nations High Commissioner for Human Rights (**OHCHR**) and the Joint United Nations Programme on HIV/AIDS (*UNAIDS) convened the Second International Consultation on HIV/AIDS and Human Rights in*

*Geneva, from 23 to 25 September 1996.*[2] The Guidelines were drafted during this Consultation.

- In *1997 the UN Commission on Human rights welcomed the Guidelines.*
- In *1998 the Guidelines were published jointly by the OHCHR and UNAIDS* and have been used as policy documents in this area and the basis for subsequent UN Commission on Human Rights Resolutions on human rights and HIV/AIDS (UN Commission on Human Rights Resolutions 2001/51; 2001/33¸1999/49; 1997/33).

## Alleviating Social and Economic Impact

### *ILO Code of Practice on HIV/AIDS and the World of Work*

The ILO is developing a Code of Practice on HIV/AIDS and the World of Work aimed at providing guidance on how the world of work can deal with workplace issues affected by the epidemic. The Code is addressed to a broad spectrum of policy makers, organizations and social partners, providing basic principles around protection of the workforce, especially those with HIV; prevention of all workers and families through information and education; promotion of concrete responses at the enterprise, within the community and at national and international levels, including regulatory frameworks, collective agreements and plans of actions. It will be promoted to all the social partners in the world of work, namely the Ministry of Labour, the employers organizations, and workers unions.

The Code of Practice will be finalised during a meeting of experts in May 2001, submitted for adoption by the ILO Governing Board and announced at UNGASS.

## Research and Development

### *Female controlled methods*

**Female controlled methods** are of particular relevance to the HIV prevention agenda because the overwhelming majority of all HIV infections result from contacts between men and women. Yet, all presently available methods for HIV prevention are mainly under male control: this is obvious for the condom, less obvious for behaviour. But women are most often the less powerful partner in a sexual relationship, which is frequently initiated at a time not of their choice (often too early) or with partners not of their choice, they often have difficulty refusing sex, even if they know their partner is at risk or known to be infected, or are not even being asked to consent. They are also at risk only because of the risky behaviour of their sole male partner. If this situation could be partly reversed there would be major favorable impact on the HIV epidemic. This requires that women be given the tools to protect themselves, such as the female condom, that they be empowered and that new products be developed to expand their ability to protect themselves.

[2] The Second International Consultation on HIV/AIDS and Human Rights (E/CN.4/1997/37) brought together 35 experts in the field of AIDS and human rights, comprising government officials and staff of national AIDS programmes, people living with HIV/AIDS (PLHAs), human rights activists, academics, representatives of regional and national networks on ethics, law, human rights and HIV, and representatives of United Nations bodies and agencies, non-governmental organizations and AIDS service organizations (ASOs).

### *Microbicides*

A microbicide is any substance that can substantially reduce transmission of sexually transmitted infections. It can be produced in many forms (e.g., gels, creams, suppositories).

### *Diagnostics*

Diagnostics are technical tools that help to reach a diagnosis. They are roughly divided into laboratory techniques (blood tests, urine tests, assessment whether micro-organisms are present and responsible for a disease) and imaging techniques (radiology and scanning procedures).

### *Vaccines*

As indicated with other diseases, vaccines are among the most cost-efficient health interventions. A highly effective vaccine against HIV infection may well be the most cost-effective solution to curb the HIV/AIDS epidemic, especially in developing countries. Such a vaccine, however, is not yet available.

## HIV/AIDS in Conflict

### *DPKO Code of Conduct*

The existing Code of Conduct for the UN Department of Peacekeeping Operations (DPKO), which was written in 1997, contains elements related to risk behaviour, but does not specifically mention HIV/AIDS. In 1998, UNAIDS and DPKO issued a booklet entitled "Protect yourself and those you care about against HIV/AIDS", however, this does not carry the weight of the Code of Conduct. DPKO plans to review the content of the Code in the course of the next year.

## Resources

### *Current and future resource needs for the response to HIV/AIDS in low and middle income countries*

HIV/AIDS programmes have been established around the world and much has been learned about successful interventions. Countries such as Uganda. Thailand, and Brazil have shown that effective, comprehensive programmes can significantly curb the epidemic. In order to scale up the response to HIV/AIDS around the world, however, additional resources are needed. It is estimated that for a global campaign against HIV/AIDS, additional resources of 7-10 billion US dollars will be needed for an extended period of at least one decade to reverse the spread of HIV. It is assumed that such resources will come from domestic (public and private), as well as from international sources.

Building upon work done on resource needs for Africa (World Bank, the London School of Hygiene and Tropical Medicine, and UNAIDS), more recent estimates on resource needs for HIV/AIDS globally have been prepared (UNAIDS, the Mexican National Institute of Public Health and the Futures Group International), under the oversight of the UNAIDS global Reference Group on Economics and HIV/AIDS.

The results of this study indicate as a best estimate, that five years from now a total of US$9.2 billion will be needed to expand the global response to HIV/AIDS to a point where the spread of the epidemic is reversed and its impact mitigated. About half of the resources would be needed for the implementation of effective prevention programmes[3], and about half for programmes to offer care and support to those who are living with HIV/AIDS and their families[4] (see table). As current expenditures for prevention, care and support programmes are in the order of 1.5 to 2 billion, this estimate calls for about a five-fold increase in expenditure (i.e., from 1.5-2 billion to 9.2 billion). These estimates include all low and middle-income countries as defined by the World Bank, otherwise referred to as developing countries and countries in transition.

| **Current and 5-year projected costs of expanded HIV/AIDS prevention, care and support programmes in US$** | | |
|---|---|---|
| | Current (2001) | 5-year Projected (2006) |
| CARE & SUPPORT | 1.0 billion | 4.4 billion (3.2 to 5) |
| PREVENTION | 0.8 billion | 4.8 billion (4 to 6) |
| **TOTAL** | **1.8 billion** | **9.2 billion** |

This study builds up on a country by country analysis and takes into account the level of the epidemic, the strength of existing care and support systems and infrastructures, level and strength of existing programmes, the level of social mobilization for HIV/AIDS, and the wealth of the country concerned (as measured by GNP). Based on these parameters, a model was developed to assess current levels of interventions as well as ambitious but realistic targets of these within five years. Where available, the baseline values and assumed targets were anchored in existing data and studies. Cost estimates were done applying unit cost data from existing studies from around the world to the country specific baseline and target values.

Both baseline and target coverages of specific interventions vary substantially from country to country and by intervention. As an indication, five year target coverage levels for treatment with antiretroviral therapies reach 43% of all people living with HIV/AIDS with symptomatic disease in low and middle income countries, with levels less than 20% in countries with the weakest infrastructures and resources, and up to 80% in the strongest countries.

It is important to note that these resource needs estimates are incremental or, in other words, they are additional to other development resources. They do not include resources for building basic infrastructures (e.g., hospitals), as those infrastructures would not be solely for HIV/AIDS and thus need to be costed in a broader programme.

[3] Package of interventions included in the costing estimates for prevention: Interventions focused on youth, sex-workers and their clients, injecting drug users and men who have sex with men; condom social marketing; public sector condom provision; improved management of sexually transmitted infections; voluntary counselling and testing; workplace, blood safety, mother to child transmission, mass media, start-up capacity and development

[4] Package of interventions included in the costing estimates for care and support: Palliative care, diagnostic HIV testing, treatment of opportunistic infections (OI), OI prophylaxis in symptomatic patients, antiretroviral therapy and its associated laboratory support, support to children orphaned by AIDS.