



Joint United Nations Programme on HIV/AIDS

**UNAIDS**

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## **PROGRAMME COORDINATING BOARD**

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**Provisional agenda item 1.3**

### **Report by the Executive Director**

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#### **1. Introduction**

This is the 10<sup>th</sup> Meeting of the Programme Coordinating Board and the Third *ad hoc* thematic meeting. I wish to thank the Brazilian Government for hosting this meeting, and for creating the opportunity to learn more about the response by the Brazilian Government and people to HIV/AIDS, in the field visits and associated presentations. I also wish to take this opportunity to thank the Brazilian Government for its financial contribution to UNAIDS.

This thematic meeting will examine in detail the “Strategic Framework for Global Leadership on HIV/AIDS”, together with substantive discussions on the 5-year Evaluation of UNAIDS, the developing UN System Strategic Plan and the forthcoming United Nations General Assembly Special Session on HIV/AIDS. This meeting’s focus is therefore on strategic planning and a unified response to HIV/AIDS at the global level. It reflects the considerable groundwork and planning on the part of the UNAIDS Cosponsors and the Secretariat to make the respective global initiatives not only possible, but meaningful and genuinely useful to efforts against the epidemic.

In accordance with usual practice at a thematic rather than a regular meeting of the Programme Coordinating Board this report will be brief, and highlight major developments since the PCB meeting in May and key strategic considerations for the immediate period ahead.

## **2. The tide is turning**

In the first half of this year, I argued consistently that the tide is turning on AIDS, in relation to political commitment, new resources, and new alliances to combat the epidemic. Events of the second half of the year suggest that this prediction was correct:

- HIV visibility and advocacy have moved to a higher level, with an increasing number of heads of government personally involved. For example, at the United Nations Millennium Summit in September, many heads of state and government used their precious five minutes to speak about AIDS (including six PCB members);
- national AIDS Councils have been created in many countries, particularly in Africa;
- the Durban World AIDS conference saw the emergence of a new international consensus, especially in relation to key issues in access to care;
- a new level of support for tackling communicable diseases, including HIV/AIDS, has emerged at the G8, in the EU, and on the part of a number of key countries including the USA and Japan;
- regional efforts have intensified, especially in Africa and the Caribbean; and
- umbrella programmes for World Bank loans focussed on AIDS have been announced for Africa and the Caribbean.

We sought new commitments and new partnerships and they have now materialised. Our focus must now shift to seeing that this new promise is fulfilled, by ensuring that new resources at the levels required actually appear, and that the mechanisms are in place to allocate these resources in a way that has a material impact on the course of the epidemic.

### **2.1 State of the global epidemic and country level responses**

The AIDS epidemic update released for World AIDS Day at the beginning of this month shows the epidemic is continuing to grow with a total of 5.3 million new infections around the world in 2000. The total number of people now living with HIV/AIDS is over 36 million, and the cumulative number of deaths since the beginning of the epidemic is 21.8 million.

In Eastern Europe 700,000 people are now living with HIV, compared with 420,000 just a year ago. Most of these new infections are among injecting drug users. The situation is particularly dramatic in the Russian Federation, where more people were infected with HIV in 2000 than in all previous years combined.

In South and Southeast Asia, an estimated 700,000 adults, 450,000 of them men, have become infected this year. By the end of the year, the region will have approximately 5.8 million people living with HIV or AIDS accounting for 20% of all infections worldwide. East Asia and the Pacific is still keeping the epidemic at bay, with some 130,000 new infections this year, bringing the number of infections to 640,000, or just 0.07% of the adult population – the lowest of all regions in the world.

In the world's wealthier countries, prevention efforts have stalled. In 2000, about 30,000 adults are believed to have become infected in Western Europe, and 45,000 in North America, the bulk of whom are thought to be injecting drug users. Evidence from gay communities of increased levels of unsafe sex by gay men in some cases seems to be translating into increased rates of HIV infection. As well, antiretroviral therapy continues to have the major impact on the pattern of the epidemic. The net effect of increased transmission through drug injection balanced by positive impacts where therapy is optimised, is the consolidation of the epidemic within immigrant, refugee, poorer and ethnic minority populations.

WHO, together with the Secretariat and major donors, have continued to strengthen national surveillance capacity on HIV/AIDS and Sexually Transmitted Infections, and promoted the development and implementation of second-generation surveillance principles at national level, together with strategic HIV surveillance plans at national, regional and global levels.

### **2.1.1 Latin America and the Caribbean**

I also want to say a few words about Brazil and the region we are in.

Brazil has emerged as a new model in the response to HIV/AIDS, with a combination of effective prevention interventions, including those involving men who have sex with men, and a rights-based approach to care, together with a local pharmaceutical industry producing generic antiretrovirals. There are now an estimated 540,000 people living with HIV in Brazil, of whom 90,000 are receiving antiretroviral therapy.

There has been considerable success in technical exchange between Brazil and other countries in the Latin American region as well as between Brazil and lusophone countries of Africa.

In Latin America and the Caribbean, the epidemic is complex, driven by heterosexual sex, homosexual sex and injecting drug use. Some 150,000 new infections were recorded this year, and 1.4 million people were estimated to be living with HIV/AIDS.

The Forum 2000 conference on AIDS held in Rio in November demonstrated the extent of horizontal cooperation and the strong role of non-governmental organizations in the response of the region. Latin America and the Caribbean have been leading examples of the power of transferring experience, knowledge and technology. The Horizontal Technical Cooperation Group brings together more than 20 Latin American and Caribbean national AIDS programmes, and regional technical

networks exist for strategic planning, epidemiology and surveillance, and injecting drug use harm reduction.

The Forum 2000 conference and its associated community forum also highlighted the continuing need for scaled-up programmes targeting men who have sex with men. While homosexual transmission constitutes 40% of transmission in Latin America, less than 1% of AIDS programme budgets goes to prevention for men who have sex with men, with the exception of Brazil which devotes significant resources to this area.

Progress in the UNAIDS response to HIV in Latin America and the Caribbean is along three key lines: advocacy, capacity strengthening through support for regional horizontal cooperation and exchange, and specific sub-regional initiatives.

As requested by the Board, we have intensified our efforts in the Caribbean, and more recently also in Central America.

In the Caribbean the Prime Minister of Barbados hosted a Caribbean Meeting on HIV/AIDS in September, with the sponsorship of CARICOM, WHO/PAHO, the World Bank and the UNAIDS Secretariat. The meeting represented a breakthrough in political support as well as the announcement of a World Bank loan programme for HIV/AIDS, together with other resource commitments. That meeting was the culmination of two years careful planning using a strengthened UNAIDS Caribbean team and working through CARICOM to bring together all the key regional players.

Central America is emerging as a region where the epidemic is increasing its pace and where greater attention needs to be placed on directing responses to priority areas, for example the epidemic among men who have sex with men. Honduras, Guatemala, El Salvador and Belize are all showing significant increases in infection rates.

### **2.1.2 Africa and the International Partnership against AIDS in Africa**

Sub-Saharan Africa continues to be the region by far the worst affected, with 3.8 million new infections in 2000, which for the first time was a lower total than the previous year's estimate of 4 million new infections. However, it is difficult to interpret the significance of this. A slow decrease in the overall number of new infections on the continent may be as a result of effective prevention programmes, either in high-prevalence situations such as Uganda and Zambia, or in the maintenance of low prevalence such as in Senegal. As well, though, it may come in part from natural saturation effects in the worst affected countries, where much of the population liable to be infected has already become so. It is also important to remember that this situation will not necessarily be sustained in future years. For example, even a modest rise in Nigeria's current prevalence at just over 5 per cent could rapidly add to the number of new infections in sub-Saharan Africa given that it is by far the region's most populous nation.

The International Partnership against AIDS in Africa is designed to be the key lever for generating more effective and sustained national responses to AIDS on the African continent. It has seen at least sixteen African nations intensify their responses against

AIDS, setting up high level multi-sectoral AIDS commissions, bringing in new funds, involving donor and private sectors more effectively and integrating AIDS plans into financial and economic planning. The Framework for Action of the IPAA has been the platform for securing common commitment to the partnership and to its milestones, including from the Heads of State Summit of the Organisation of African Unity held in Lome in July.

The International Partnership against AIDS in Africa has generated new resources especially by mainstreaming AIDS into country level Poverty Reduction Strategy Papers and in negotiations to alleviate foreign debt under the Highly Indebted Poor Country (HIPC) initiative. Over the past 12 months, more than a dozen countries have inserted the main lines of action from their national AIDS plans in their national poverty reduction strategies or set HIV/AIDS targets within their national poverty monitoring indicators. Many countries have for the first time set aside funds from their own national budgets, as part of the HIPC debt relief process, to finance part of the national AIDS response. In total, the poorest countries of Africa will spend an additional \$20 million on AIDS next year from their own resources. The debt relief process also involves countries committing to and monitoring AIDS prevention care and support activities with civil society and international partners over the next 12 to 24 months. These processes have supported District Response Initiatives, in particular in Uganda and Tanzania, with key support from UNICEF, the World Bank and the Secretariat. As well as the activity in specified debt relief nations, a number of middle income African countries are also increasing their spending on AIDS.

At the second Africa Development Forum on 'AIDS – the greatest leadership challenge' in Addis Ababa, the International Partnership against AIDS in Africa was formally launched by the United Nations Secretary-General where he declared that "from now on, across all of Africa, it will be the focus for a new spirit of co-operation in building the response to AIDS".

The Forum was convened by the Economic Commission for Africa (the regional arm of the United Nations, mandated to support the economic and social development of its 53 member States) and its conduct and outcomes place HIV/AIDS firmly on the ECA's agenda. A considerable part of the substantive discussion and materials for the Forum were provided by the UNAIDS Secretariat, together with major involvement of the Co-sponsors. The meeting was notable for its high level participation, with at least seven heads of State/Government attending, together with a broad range of other participants including substantial representation of people living with HIV/AIDS and a youth contingent. There was a great sense of urgency about the response to HIV/AIDS in Africa. Mrs. Graca Machel gave a powerful keynote address where she said "any international support ... can only be in addition to our own efforts and it will be our own efforts that bring us rewards in this struggle".

The Forum identified political leadership and the involvement of people with HIV as key to progress in a full-scale and effective response to HIV in Africa. It appealed to UNAIDS Co-sponsors and the Secretariat to increase their support, especially in relation to resource mobilisation and coordination, and strengthening of newly created National AIDS commissions and agencies, and to intensify their activities in access to care and treatment, as well as prevention among young people.

## 2.2 National and international mobilization

Progress in mobilizing the international community over the last six months has been considerable. Not only are national political leaders speaking out in unprecedented ways, but also the most influential global groupings are increasingly highlighting the question of AIDS.

A response to HIV/AIDS on the necessary scale demands that national governments mobilize their own resources in a more sustained fashion than hitherto. Over the past year there have been a number of indications of substantially increased support from within developing countries' own budgets for action against HIV/AIDS. For example, the Nigerian government has allocated about \$40m in its 2001 appropriation bill to be administered by the National Action Committee on HIV/AIDS, in addition to the \$80m in financial assistance from multilateral and bilateral institutions. Other examples include increased allocation in South Africa and an AIDS-levy in Zimbabwe. In addition, broad based resource mobilization round tables have occurred in Malawi, Zambia and Mozambique, bringing together national, private sector and international stakeholders to identify additional funding.

The Okinawa communiqué from the G8 meeting in July announced an ambitious plan of action on infectious diseases acknowledging that health is central to economic development, and that of all the communicable diseases linked to poverty, HIV/AIDS has the largest impact on individuals, families, sectors and nations. More detailed strategies, goals and target have been mapped out at the follow-up Okinawa International Conference on Infectious Diseases on 7 and 8 December, in which the UNAIDS Secretariat worked closely with WHO, the World Bank, UNICEF and the Japanese government.

In September the European Commission convened a high level Round Table meeting, cosponsored by UNAIDS and WHO, to explore the European Union's role in new action and partnerships against communicable diseases and poverty. Its emphasis was on optimizing the impact of existing national interventions; improving the affordability of pharmaceuticals; and increasing investment in research and development. Significantly, a number of Commissioners have been involved in the initiative, led by development and including health, science and research, and trade. In November the European Union adopted a Resolution on Communicable Diseases and Poverty which stressed: a multi-sectoral approach, including prevention and strengthening of health care systems; better co-ordination at the global level; a larger effort between European and developing country researchers; and reinforced links with WHO and UNAIDS.

Successful advocacy at the global level has resulted in increased political commitment and may soon translate into substantially increased resource pools. If and when new resources are made available, they must be deployed in a way that is consistent with the understandings we have gained over the course of the epidemic of what works. In particular, resources need to flow as efficiently as possible to support local responses which partner government and civil society, within frameworks set by national government priorities. We know that attempts by the international community to impose priorities against the will of national governments are not only inappropriate,

they are also doomed to failure, and equally that the proliferation of small projects which seek to bypass national and local decision-making simply results in inefficiency and unsustainability.

### **3. Prevention and care**

Reversing the HIV/AIDS epidemic will require substantial progress in the provision of both prevention and effective care. Prevention must remain a priority, but it cannot be seen in isolation from the needs of the millions of people already infected with HIV. The biggest current opportunity for making progress on both prevention and care derives from the understanding that they work best when they work in tandem. In particular, prevention and care share a number of core objectives, such as encouraging openness, involving people with HIV, and supporting voluntary counselling and testing.

#### **3.1 The unfinished prevention agenda**

Although many of its elements are well understood, much of the prevention agenda remains unfinished, especially when it comes to its implementation at scale.

First, the need to go to scale is over-riding. The capacity to absorb additional implementation exists, providing that it is directed to the right areas. In particular, there is a need for non-bureaucratic mechanisms to direct resources rapidly towards local responses. Local response experience continues to accumulate in many different settings. Examples from Gaoua in Burkina Faso and Phayao in Thailand show local responses generating HIV/AIDS activity across all sectors at local level, as well as creating models that can be adopted in many other settings.

Second, there is a continuing need to promote a focus on youth as a particular priority. The United Nations target of a 25% reduction in HIV infection in people aged 15-24 is a platform around which a youth focus can be built. Often, even the basics of a youth program are lacking: there are too many countries where a majority of sexually active teenagers do not know the basics of transmission, and too many countries do not provide their youth with sex education.

The Cosponsors have increased collaboration on youth issues at global level. The interagency task team on young people met in August 2000 hosted by the World Bank to come up with core priority areas for programming on young people. The UNICEF Interregional Working Group on Young People in Crisis in Kampala in November 2000 focused on young people in situations of armed conflict, street youth and HIV/AIDS among young people. WHO and UNICEF Europe are addressing sexual behaviour and substance use among especially vulnerable young people in the Baltics and Poland. UNFPA, with funding from the Gates Foundation, has increased programming on young people, with a special emphasis on adolescent girls. In its Act Africa programme, the World Bank is encouraging governments to provide school fees, care of children, nutrition and succession planning for young people affected by AIDS.

Third on the unfinished prevention agenda is that condom supply still cannot be guaranteed everywhere. For example, a number of African countries have run out of stocks of male condoms. Progress on the availability of female condoms has been slow, although evidence mounts of their acceptability. This remains an urgent issue for 2001. UNFPA has become the international procurement agency for male and female condoms for use in HIV/AIDS prevention programmes, and both WHO and UNFPA have intensified their male and female condom-related efforts.

The fourth unfinished agenda item is the prevention of mother to child transmission. UNICEF is conducting pilot projects on the implementation of interventions to prevent mother to child transmission in 12 countries, and considering their extension to a further 12. In October in Geneva a technical meeting on behalf of the UNICEF, UNFPA, WHO, UNAIDS InterAgency Task Team on the Prevention of Mother-to-Child Transmission of HIV concluded that antiretroviral regimens have been shown to be effective and safe and therefore should now be made available beyond pilot projects and research settings. These technical recommendations have been given added salience by the July announcement from Boehringer that it would donate nevirapine for the prevention of mother to child transmission in developing countries, although in most cases implementation arrangements are still to be finalised.

A fifth unfinished agenda is the prevention of HIV among injecting drug users that continues to drive the epidemic in a number of regions, and in particular the explosive spread in Eastern Europe. Our newest Cosponsor, UNDCP is increasingly active in the complex area of HIV among injecting drug users. In Latin America, for example, a joint plan of action on injecting drug use and HIV/AIDS will be implemented in conjunction with the National AIDS Programmes and the partner nongovernmental organizations in Argentina, Uruguay, Paraguay and Chile.

UNDCP also plays a key role in various discussion forums among policy makers, for example the London meeting on multisectoral responses to HIV and injecting drug use on 7-8 December 2000, convened by UNDCP together with WHO, UNICEF, the UNAIDS Secretariat and DFID from the UK, whose participants included 20 Deputy Ministers from the Russian Federation, Belarus, Kazakhstan and Ukraine. With support from the UNAIDS Secretariat, UNDCP has established a drug use and AIDS post. UNDCP also worked closely with the UNAIDS Secretariat and WHO in drafting a position paper for the UN system on "preventing the transmission of HIV among drug users".

### **3.2 Accelerating access to HIV care**

The emerging care agenda across the globe takes a broad-based approach, not one that looks only at antiretroviral access, though public attention has seemed to be narrowly focussed on the price of antiretrovirals. There is a need for affordable drugs, including antiretrovirals, but they also need to be delivered safely and in a way that maximises the chances of therapeutic success. So drug supply and distribution must be sustainable, and equal attention is required across the total continuum of care – from home based to hospital, from treatment of infections to palliative care.

'Accelerating Access to HIV Care' represents a redoubling of efforts by UNAIDS (particularly UNICEF, UNFPA, WHO, the World Bank and the Secretariat) to assist countries in implementing comprehensive packages of care for people living with HIV/AIDS. It includes advocacy and policy guidance on HIV care at the global level and also involves "fast track" support for those countries which have formally indicated that they wish to significantly expand access to HIV care, support and treatment, and who want assistance from the UN system. The comprehensive approach to care advocated by UNAIDS explicitly includes voluntary counselling and testing and psycho-social support, prevention and treatment of opportunistic infections, good nutrition, strengthening of health systems, fair and sustainable financing and, where possible, access to antiretroviral drugs. UNAIDS recognizes that national governments, alone or in regional groupings, are the key bodies empowered to conclude procurement agreements and price levels with industry. The UN system's role is mainly to advocate, to engage in dialogue and to provide information, technical and policy advice to help the process along. We are also exploring how to use existing global procurement mechanisms in an expanded and more strategic way.

In Geneva in September 2000 the first meeting was held of the Contact Group, the forum proposed by the WHO Director-General at the May 2000 World Health Assembly, and endorsed by the PCB, to advise UNAIDS on issues relating to access to HIV care and support. Its first meeting clarified the terms of the access debate as well as calling for better communication and for clarification of how countries and regions can participate in accelerating access. The Contact Group reviewed progress internationally and at the country level at its meeting in Rio on 13 December. [A report on this meeting held immediately prior to the PCB will be presented]

Progress on Accelerating Access over the past three months has been significant.

In October 2000, the UNAIDS Secretariat, together with WHO, UNICEF and UNFPA posted a call for Expressions of Interest from pharmaceutical companies and those providing other commodities, to widen the range of available HIV diagnostics and medicines and increase the number of potential suppliers using existing procurement mechanisms, particularly through UNICEF and UNFPA. The deadline was 1 December 2000. Responses were received from 34 manufacturers for more than 100 pharmaceuticals and 11 manufacturers of diagnostics and laboratory material. The applications are now being evaluated and once completed, information on suppliers and indicative prices will be made available to government and non-governmental procurement agencies.

Several African countries are now actively planning to expand access to care for people with HIV. In Swaziland, a three stage care and support plan has been developed on more efficient delivery, increased capacity and advanced treatment options. In Uganda, expansion of the Drug Access Initiative has been planned and the Government announced on December 2 that it was continuing negotiations with drug companies on reduced prices for antiretroviral drugs. The Central African Republic developed a health sector plan that increases access to all care, including pilot introduction of antiretrovirals. In mid-October, the Government of Senegal announced that it is extending its existing plan on access to HIV/AIDS related care and treatment to include access to antiretroviral therapy. It has already introduced prophylaxis for opportunistic infections with cotrimoxazole.

Fourteen countries have requested to participate in 'Accelerating Access to HIV Care'. More detailed information on country progress and results of the Expressions of Interest from commodity suppliers is included in the update of the Contact Group Meeting on Accelerating Access to HIV related care which took place on 13 December.

There are many unresolved issues and several areas of concern in the care agenda. Paramount is the need to maintain the comprehensive care agenda, and prevent its hijacking by a solely antiretroviral or a commercial agenda. Not all the pharmaceutical companies have accepted equity pricing. The capacity of the UN system to respond to the demand from countries is a challenge, given the approach we have adopted of advising countries on their overall care strategy so that they then can choose among the available options, rather than merely promoting a short-term antiretroviral focus, and that the options encompass various sources of drugs, including those from research and development companies as well as quality generics. Additionally, to the extent that country level initiatives focus on the affordability of antiretroviral and other drugs, they must proceed in a sustainable fashion, without creating unstable and untenable distortions in patterns of care provision or adding to inequities in health care access. Finally, we have only just begun to address the issue of the financing of HIV care in the poorest countries.

The care agenda is a matter of careful balance between realism and optimism. Even in wealthy and middle income countries, there remain important equity issues in ensuring access across all sectors of the population. However, universal access to antiretrovirals is not possible today in the world's poorest countries given current levels of drug prices and internal and external resources, just as there is no universal access to cancer treatment, renal dialysis etc. nor of treatments for opportunistic illnesses. Nevertheless, we need to wade in and create new opportunities step by step, acting rapidly and creating parallel tracks to increase available options. There is no simple nor single solution but we need to maintain progress by steering a course that avoids demagoguery in either direction (nihilism or adventurism) but instead focuses solely on making real progress for people living with HIV.

It also gives rise to a new deal between industry and society whose elements include the recognized moral legitimacy of preferential pricing on proprietary drugs for developing countries, and the need for incentives for innovation on the part of industry, together with a recognition that intellectual property rights are not some form of transcendent holy writ but property rights that exist in the normal context of national sovereignty and humanitarian interest.

#### **4. United Nations General Assembly Special Session on HIV/AIDS (UNGASS)**

The United Nations General Assembly Special Session on HIV/AIDS will be held from 25 to 27 June 2001. The session aims to secure global commitment to enhanced coordination and intensification of national, regional and international efforts against the epidemic. This represents an extremely important opportunity to consolidate the position of HIV at the top of the global political agenda and focus on support from multiple sectors.

The UNGASS process will be an innovative one. The Session itself will comprise a plenary meeting and interactive round-tables. The UNAIDS Secretariat will act as the substantive Secretariat and a New York based Reference Group has been set up to coordinate UN system preparations. The outcome document will be a Declaration of Commitment including existing HIV/AIDS goals as well as selected new ones (e.g., on access to care and treatment and on orphans).

The UNGASS will reflect the partnership approach to the global response to AIDS by ensuring the active participation of civil society representatives in the special session and its preparation. The involvement of AIDS non-governmental organizations and people living with HIV will be critical to the success of the Special Session.

In order to maximize the utility of the UNGASS considerable country preparation will be necessary. The UNGASS will build on a number of already planned meetings of key regional groupings such as the Organization of African Unity.

## **5. The United Nations Response**

Despite the achievements of the past six months, the task ahead remains daunting. Success over the past year in global advocacy has been matched by a heightened level of activity among the UNAIDS Cosponsors and in the UN system as a whole. AIDS has become the highest priority for a number of Cosponsors in a number of regions. In addition to this continuing high level of activity on the part of each of the Cosponsors, I want today to focus on non-cosponsoring multilateral organisations.

The UN Secretariat has become engaged with HIV/AIDS in a more substantive way. This engagement has included the interest of the United Nations Economic and Social Council together with the UN Administrative Committee on Coordination in the United Nations System Strategic Plan for HIV/AIDS for 2001-2005. There has also been a strong engagement with the full range of HIV/AIDS issues on the part of the United Nations Secretary-General and the Deputy Secretary-General, for whom AIDS is now part of their core agenda.

The International Labour Organization is rapidly emerging as a key player in the UN response against AIDS, building on its tripartite constituency of governments, workers and employers.. The ILO has established a 'Global Programme on HIV/AIDS in the World of Work' that includes focal points both at headquarters and field offices to provide support for an organization-wide AIDS initiative. A memorandum of understanding has been signed between the UNAIDS Secretariat and the ILO, which is keen to become a Cosponsor in the near future. The International Labour Conference in June 2000 adopted a resolution calling on employers, employees, and government ministries to strengthen HIV/AIDS prevention and impact mitigation and the ILO has become an active participant in an increasing number of Theme Groups on HIV/AIDS.

The Food and Agriculture Organization of the United Nations (FAO) has been collaborating with the World Bank and the Secretariat on assessing HIV dynamics in rural areas. FAO has also been involved in the development of a package providing

information and tools for gender and AIDS programming, together with the UNAIDS Co-sponsors, ILO, the United Nations Division for the Advancement of Women (UNDAW), and the United Nations Development Fund for Women (UNIFEM).

UNDAW has adopted the issue of Gender and AIDS as one of two themes for the forthcoming session (March 2001) of the Commission on the Status of Women. It will work with the Commission's member states towards formulating a resolution or an agenda for action by governments on addressing gender obstacles to AIDS prevention and care.

UNIFEM has completed the first phase of the global initiative on 'Gender Focused Responses to Address the Challenges of HIV/AIDS', which was implemented in India, Vietnam, Zimbabwe, Senegal, Mexico and the Bahamas. Through capacity-building and partnership activities, the project has successfully integrated gender and AIDS concerns into existing programmes of women's organizations. Three modules on gender and development, gender and human rights, and negotiation skills have been produced.

The International Office for Migration is playing an important advocacy role for greater recognition of migration as key factor in HIV dynamics. It has been active at regional and national levels in Ethiopia, South Africa and South East Asia. As well, UNDP, the World Bank, and the Secretariat have continued to collaborate on incorporating migration into strategic planning and policy development.

Following UN Security Council Resolution 1308 of 17 July 2000, UNAIDS Co-sponsors and the Secretariat are developing a range of activities on the issue of HIV/AIDS in peacekeeping operations. In collaboration with the United Nations Department of Peacekeeping Operations and others, the UNAIDS Secretariat organized a major meeting in Stockholm from 11 to 13 December 2000 to draft a global plan of action for the prevention and control of HIV in peacekeeping operations.

UNAIDS is now pursuing a number of issues in the area of humanitarian work, including care and prevention for peacekeeping forces and the general issue of HIV vulnerability in conflict situations, including in its gender dimensions. In this context, the UNAIDS Secretariat and its Cosponsors have undertaken several assessment missions since October 2000 (to Ethiopia, Eritrea and East Timor), and missions are planned to Haiti and Sierra Leone. Other first phase countries selected for missions are Angola, Cambodia, Colombia, Congo, Democratic Republic of Congo, and Rwanda.

We are looking forward to the five-year Evaluation of UNAIDS including all HIV activities in Cosponsors, that will commence in earnest early in 2001. The extraordinary meeting of the PCB in October in Geneva clarified the mandate that will guide the process for the evaluation. That process is necessarily and appropriately an independent one, and we will give our full co-operation to the evaluation team. The Evaluation will be discussed in detail later on the agenda.

Within the UNAIDS Secretariat, a realignment has just been carried out to help the Secretariat better focus on its core roles of knowledge management, generating and

disseminating strategic information, and supporting expanded country activity. The existing departmental arrangement has been replaced with two new departments, one focussing on country and regional support, which will include cross-cutting teams on key emerging issues, and a department of social mobilization, advocacy and knowledge management.

## 6. The continuing challenge

There remains ahead of us a huge unfinished agenda, together with an agenda that we have hardly even begun. Let me specify the five most pressing items on this agenda for the world community, in addition to those I discussed earlier in relation to HIV prevention and care, together with the five most pressing challenges for UNAIDS and the United Nations system.

### 6.1 The Global Agenda

First: we still need a renewed effort to **combat stigma**. This calls for an all out effort, by leaders and by each of us personally. Effectively addressing stigma removes what still stands as a roadblock to concerted action, whether at local community, national or global level, so action against stigma ramifies across every single aspect of HIV work.

Second, we have to be more conscious of the **impact of the epidemic on social capital**. How will education continue when teachers are dying faster than they can be replaced? How will agriculture be maintained when farming skills are lost? How is industry maintained when skilled workforces are diminished? Planning to fill the gap in the human resources needed to replace those lost to AIDS has to be squarely on the new agenda and needs to be placed alongside the realisation that people living with HIV themselves represent the greatest untapped human resource in the struggle against AIDS and in developing the resilience to withstand its impact.

Third, we have barely begun the process of **institutional behaviour change** and widening the range of institutions and movements in our ambit. Private sector change is only just beginning. Unions have begun to show how they can play a role. The women's movement is only beginning to fully engage with AIDS on its agenda, an agenda that will no doubt be able to gain additional momentum as it taps into the experience of the many AIDS service organizations across the world that are headed by strong women.

Fourth, the mobilization of **resources**, scaling up investment and tapping new sources of finance, is beginning to move to a higher level. New resources need to be deployed on the systematic and sustainable alleviation of the impact of AIDS. New, non-bureaucratic mechanisms are needed to channel these resources efficiently to the district level where they really make a difference. AIDS resources are not about short-term projects. Debt relief has proved a useful new lever for resource mobilisation, but this agenda has just started, and in any event, the need for AIDS resources in fact constitutes the most compelling case for debt cancellation altogether.

Fifth, we have to find ways to better **support communities** to implement what they know - if they are allowed to find out – namely, what works against AIDS and how to make it a reality in their own context. The community level is where multi-sectoralism gets its true meaning.

## 6.2 The Agenda for UNAIDS and the UN System

First, current institutional commitments need to be translated into actual **capacity and resources**, mainstreaming AIDS into core activities and retro-fitting existing resource allocation programmes so that they better encompass AIDS activity.

Second, we need to **sustain political momentum**. The year 2000 has been remarkable for the extent of political momentum that has been generated, and that it has reached the highest levels. In 2001 we need to build on that momentum, and ensure that the year's various summits and conferences add value as opportunities for renewal and co-ordination, without absorbing too much of our available energy.

Third, we must improve our **support to country** level resource mobilisation and national coordination. Ensuring a well-coordinated UN response at country level through Theme Group work remains a formidable challenge. In the coming year of evaluation, we need to look honestly at what is working, and what is not.

Fourth, accelerating access to **HIV care** remains at the top of our agenda, with the principles we know provide the basis of a sustainable approach: the inseparability of prevention and care, the comprehensive care package, and attention to equity, effectiveness, sustainability and quality alongside affordability.

Fifth, we need to place **strategic information** at the core of our efforts. This entails a move away from technical assistance to a notion of leveraging technical support, just as it moves from information dissemination to a more active concept of knowledge management.

Above all, our most pressing issue is to keep alive the belief that the epidemic can be turned back. There are some examples of national and local contexts where HIV prevalence has reduced or been maintained at low levels, but the impact of the epidemic continues to grow in almost all settings. Nevertheless, a strengthened commitment and willingness of more and more communities to 'own' the problem of AIDS and devise solutions, is a basis for hope. The key challenge of the coming few years, in the face of the impact of the epidemic which will inevitably be greater because of the number of people already infected, will be to maintain and build on this sense of hope.