The Special Session of the United Nations General Assembly on HIV/AIDS in June 2001 was a landmark in the global efforts to respond to the AIDS crisis. In the Declaration of Commitment on HIV/AIDS (United Nations, 2001), for the first time, leaders from 189 Member States committed themselves to a comprehensive set of time-bound HIV targets.

By ensuring strong leadership and commitment, mobilizing unprecedented resources and delivering effective HIV prevention, treatment, care and support strategies, countries committed to halt, and begin to reverse, the global epidemic by 2015, as provided in Millennium Development Goal 6 (United Nations, 2000). In the years following the Special Session, the Declaration has galvanized substantially stronger global action, strengthened advocacy by civil society, helped guide national decision-making and served as a primary framework for monitoring the HIV response at global, regional and national levels.

Accountability and transparency are important features of the Declaration of Commitment on HIV/AIDS, which provides for regular reporting to the General Assembly on global progress in achieving the Declaration’s time-bound mandates. In fulfilment of the monitoring provisions of the Declaration, UNAIDS worked with diverse partners to develop a series of core indicators to measure global and national progress in implementation (UNAIDS, 2005a). In 2003, more than 90 countries submitted information regarding these core indicators, permitting identification of specific gaps in the HIV response at national, regional and global levels (UNAIDS, 2003).

This Global Report is being issued five years after the 2001 Special Session, as Heads of State and other national leaders are joining with representatives of civil society, the private sector and other sectors of the international community to assess progress made in the HIV response. To inform the five-year assessment of implementation of the Declaration of Commitment on HIV/AIDS, UNAIDS has again surveyed countries on the core AIDS indicators, with particular attention to several quantifiable targets that were to be reached by December 2005 (UNAIDS, 2005a). By March 2006, UNAIDS had received responses from 126 countries and territories, presented in Annex 3. The
latest country reports represent the first time countries have systematically reported data on a broader set of core indicators, including the monitoring of blood safety, risk reduction for sexual transmission, quality of AIDS treatment and the coverage of services for populations most at risk. The extensive reporting from countries stems in part from successful consultative processes undertaken at country level, the placement by UNAIDS and other partners of more than 60 technical monitoring and evaluation officers to assist national efforts (CDC/GAP, 2005), and the systematic collection by countries of relevant HIV-related data under the Country Response Information System (UNAIDS, 2005b). Also, the collaborative work of the Global Resource Tracking Consortium and the UNAIDS sponsorship of country projects to estimate the National AIDS Spending Assessments facilitated the report of actual government expenditures for HIV within and outside the health sector (UNAIDS, 2006).

This current report contains the most comprehensive set of data on the country response to the AIDS epidemic the world has ever had. Not only did 126 countries and territories submit reports, but for the first time, civil society was actively engaged in the collection, review and analysis of these data (see ‘Civil society’ chapter). In addition, UNAIDS received separate reports from civil society for over 30 countries, which allows an assessment of political commitment, quality and equity of service coverage, and how well stigma and discrimination are being addressed. UNAIDS also supported targeted coverage surveys for key HIV prevention, treatment, care and support interventions, as well as other studies on particular aspects of the global response. Indicator data from countries that reported to UNAIDS are presented in Annex 3.

Of the 126 countries and territories that submitted reports, 46 have generalized epidemics, while 76 have concentrated or low-level epidemics (four territories were not classified). Not all countries provided information for all core indicators. A few countries only provided indicator data and not a narrative report. This chapter primarily focuses on low- and middle-income countries with a special section on results from high-income countries.

The important progress made against AIDS since the 2001 Special

Not only did 126 countries and territories submit reports, but for the first time, civil society was actively engaged in the collection, review and analysis of these data.
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 now build a fully comprehensive, full-scale response. Selected countries also report improvements to national human rights frameworks, and some progress has been made in involving civil society in the development, implementation and evaluation of national responses.

In general, however, the epidemic continues to outpace the response. Prevention programmes reach only a small minority of those in need; coverage for programmes to prevent mother-to-child transmission improved only modestly between 2003 and 2005, and roughly half of countries reporting from sub-Saharan Africa failed to fulfil the Declaration of Commitment on HIV/AIDS’ target to reduce HIV prevalence among young people (aged 15–24) by 25% by 2005. Despite progress in expanding treatment access, antiretroviral drugs currently reach only about one in five of those who need them in low- and middle-income countries. Children orphaned by AIDS lag behind their counterparts in school attendance and support services reach only about one in ten children made vulnerable by the epidemic. The current level of financing for HIV activities, while more than four times higher than in 2001, represents barely one-third of the amount that will be required by 2008 to place the world on track to reverse the global epidemic.

**Leadership**

The Declaration of Commitment on HIV/AIDS provides that all countries will develop and implement sound national multisectoral HIV 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. Under the Declaration, both regional political bodies and global forums are to promote greater action and coordination on HIV, including the development of innovative public-private partnerships.

According to self-evaluation data, those countries that rated themselves as having strong political support in 2003 did not waver over the following years, continuing to report strong support for the AIDS response in 2005. Where the 2003 survey
suggested room for improvement in national political leadership, several countries appeared to take on the challenge, especially in sub-Saharan Africa, the region most gravely affected by AIDS. Approximately 85% of countries have a single body to coordinate HIV activities. In nearly 40 developing countries, the national AIDS response is led by heads of government or their deputies. All reporting countries say their head of government (81%) or other high officials (97%) spoke publicly and favourably about AIDS efforts at least twice in 2005.

On a range from 0–10 (with 10 as the highest), 91% of countries rank their national strategic planning on HIV as above average (score = 6–10), with three-quarters of countries reporting improvement over 2003. Of countries reporting to UNAIDS, 90% say a multi-sectoral strategy or action framework is in place to guide the national HIV response.
KEY FINDINGS FOR LOW- AND MIDDLE-INCOME COUNTRIES

In most countries, a strong foundation now exists on which to build an effective AIDS response. Of reporting countries, 90% now have a national AIDS strategy, 85% have a single national body to coordinate AIDS efforts, and 50% have a national monitoring and evaluation framework and plan, which fulfil the “Three Ones” principles for an effective response (see ‘National capacity’ chapter). In nearly 40 developing countries, the national AIDS response is now personally led by heads of government or their deputies.

Financial resources for AIDS have significantly increased. The rate of increase in HIV resources has accelerated since the 2001 Special Session, with an annual average increase of US$ 1.7 billion between 2001–2004, compared to an average annual increase of US$ 266 million between 1996 and 2001.

Domestic public expenditure from governments has significantly increased in low-income sub-Saharan African countries, and more moderately in middle-income countries. Among 25 low-income countries in sub-Saharan Africa, domestic public sector outlays on AIDS increased by 130% since the 2001 Special Session, reaching a total allocation of US$ 640 million in 2005. The increase among upper middle-income countries outside sub-Saharan Africa in the same period was approximately 10%.

There is increasing scientific confidence that it will be possible to develop a safe and effective preventive HIV vaccine and microbicide. However, there are many scientific challenges ahead and ensuring the timely development of both technologies will require increased global collaboration and coordination. It will also require the investment of significantly more resources. Over the last five years funding for the two technologies has increased two-fold.

Treatment access has dramatically expanded, although such efforts have fallen short of global goals. In 2005, 1.3 million people in low- and middle-income countries received antiretroviral therapies and 21 countries met or exceeded targets under the “3 by 5” initiative to provide treatment to at least 50% of those who need it.

Some countries have significantly increased coverage for prevention services, although only six have reached the prevention target of 25% reduction in HIV prevalence among 15–24-year-olds. In over 70 countries surveyed, testing and counselling services use quadrupled in the past five years from roughly four million persons in 2001 to 16.5 million in 2005. In 58 countries reporting data, 74% of primary schools and 81% of secondary schools now provide AIDS education. Some countries have achieved nearly 60% coverage of HIV-positive pregnant women receiving antiretroviral prophylaxis to prevent mother-to-child transmission (though the global average is only 9%). Blood for use in transfusions is now routinely screened for HIV in most countries.

Despite strides in increasing access to some prevention services, the epidemic continues to seriously affect women and young people. Women represent nearly half of all people living with HIV, including nearly 60% in Africa. About half of all new infections are under 25
years of age (including children through mother-to-child transmission). In parts of Africa and the Caribbean, young women (aged 15–24) are up to six times more likely to be HIV infected than young men.

HIV prevention programmes are failing to reach those at greatest risk. Only 9% of men who have sex with men received any type of HIV prevention service in 2005, with service coverage ranging from 4% in Eastern Europe and Central Asia to 24% in Latin America. Among people who inject drugs, fewer than 20% received HIV prevention services, with coverage of less than 10% reported in Eastern Europe and Central Asia, where drug use is a major driver of the rapid expansion of HIV infection. While prevention coverage is somewhat higher for sex workers, only 10 of 24 countries that reported data for sex workers achieved at least 50% coverage for this population. Nineteen countries reported that more than 50% of sex workers had used a condom with their last client. Even though the data indicate that coverage of prevention programmes is higher for sex workers than for 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.

HIV prevention efforts to increase knowledge about AIDS remain inadequate for young people, although there are encouraging signs of positive behavioural change in several countries. Although the Declaration of Commitment on HIV/AIDS aimed for 90% of young people to be knowledgeable about AIDS by 2005, surveys indicate that fewer than 50% of young people achieved comprehensive knowledge levels. In all but three countries with recent surveys, young women consistently have lower knowledge than men. On a more encouraging note, the percentage of young people having sex before age 15 declined and condom use increased in eight of eleven sub-Saharan countries studied.

Stigma and discrimination remain key barriers to the successful implementation of 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 civil society reports from over 30 countries, stigma and discrimination against people living with HIV remains widely pervasive.

The AIDS response is insufficiently grounded in the promotion, protection and fulfilment of human rights. Half of countries submitting reports to UNAIDS noted the existence of policies that interfere with the accessibility and effectiveness of HIV-related measures for prevention and care. Legal systems in many countries also fail to provide adequate protection to children affected by AIDS and to elderly caregivers. Where legal protections exist, the capacity to put them into practice is often inadequate.

National governments, international partners and communities are failing to provide adequate 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, fewer than one in ten children are reached by basic support services. Furthermore, orphans still lag behind non-orphans in school attendance.
Of countries reporting to UNAIDS, 90% say a multisectoral strategy or action framework is in place to guide the national HIV response.

More than three-quarters (78%) of countries indicate that their national HIV framework has been incorporated into the country’s general development plans. This reflects a political recognition of the central importance of a strong AIDS response to the country’s development prospects and may increase the likelihood that AIDS will be addressed from a multidimensional perspective that takes into account the multiple sources of HIV-related vulnerability. However, just over half (56%) of countries with a generalized epidemic have evaluated the impact of AIDS on economic development—no improvement over reports provided in 2003.

The impact of any national plan depends in large measure on the degree to which it is successfully implemented. Of 73 countries reporting that they have a national strategy or framework, just over half (53%) have an operational plan with formal programme goals, detailed budget costs and specified funding sources. In many countries, multisectoral plans have yet to be converted into broad-based action, with programme implementation and budgetary allocations for HIV often still heavily concentrated in the health sector.

In most countries, civil society groups surveyed by UNAIDS say the national government has made modest—and in some cases, strong—efforts to increase civil society participation. In several countries in Africa, Asia and Europe, however, civil society informants say they have not been adequately involved. Civil society engagement is greatest with respect to HIV planning and budgeting (79% reporting above-average engagement), but less apparent in the monitoring of national efforts. More than one-third (39%) of civil society reports cite very low participation in a periodic review of national strategies. In roughly one in four countries (22%), services delivered by civil society groups are not integrated into the national HIV coordination mechanism. With respect to the inclusion of people living with HIV and their caregivers in the review of protocols for HIV-related human subjects research, 71% of civil society reports rate such engagement as average or below, with almost one-third (31%) rating it very low.
Although the number of private sector companies expecting AIDS to have an impact on their business in the next five years increased from 37% to 46% between 2004–2005 and 2005–2006, only 6% of private companies worldwide have a written HIV policy. In countries where HIV prevalence exceeds 20%, a majority of companies (58%) have written policies. To date, business action on HIV has primarily focused on HIV prevention, with fewer companies making provision for the delivery of antiretroviral drugs.

While no quantifiable indicator has been developed to gauge regional action on HIV, it is clear that it has grown since 2001 together with regional collaboration. In recognition of the central role of the Pan Caribbean Partnership against HIV/AIDS (PANCAP) in strengthening the AIDS response of Caribbean nations, UNAIDS in 2004 formally recognized PANCAP as an example of international best practice. Established in 2002 in response to the Declaration of Commitment on HIV/AIDS, the Asia Pacific Leadership Forum on HIV/AIDS and Development supports and strengthens political and civil society leadership in Asia, in part through the provision of technical support in more than 12 countries. In 2005, 11 Latin American countries joined together to negotiate price reductions of up to 66% from 26 makers of antiretroviral drugs. Both the European Union and the Commonwealth of Independent States have prioritized stronger action on AIDS in Eastern Europe and Central Asia. In March 2006, representatives from 51 countries of the African Union endorsed the Brazzaville Commitment on Scaling Up Towards Universal Access to HIV Prevention, Treatment, Care and Support, at a continental consultation organized by the African Union with the support of the UN. This Commitment, which set the tone, pace and direction for AIDS policy in Africa until 2010, was the fruit of intense discussions based on national consultations in 41 African countries.

Since 2001, HIV has remained near the top of the global political agenda. In 2005, the United Nations World Summit endorsed the goal of moving towards universal access and reiterated global resolve to achieve the time-bound targets in the Declaration of Commitment on HIV/AIDS (United Nations, 2005). Likewise, in the official communiqué following their annual 2005 summit, the Group of Eight (G8) industrialized countries formally embraced the goal “to develop and implement a package for HIV prevention, treatment and care, with the aim of as close as possible to universal access to treatment for those who need it by 2010” (G8, 2005) The Group of 77 countries, in its 2005 Doha Declaration, called for enhanced South-South cooperation to implement prevention, treatment, care and support measures, with particular emphasis on the need for programme scale-up in least developed countries (Group of 77, 2005).

**Prevention**

Citing HIV prevention as the “mainstay of our response,” the Declaration of Commitment on HIV/AIDS calls for country-tailored, comprehensive prevention programmes to be available in all countries by 2005. The Declaration targeted a 25% reduction in HIV prevalence among young people (aged 15–24) in the most affected countries by 2005, as well as a 20% reduction in the proportion of infants infected with HIV. According
Citing HIV prevention as the mainstay of our response, the Declaration of Commitment on HIV/AIDS calls for country-tailored, comprehensive prevention programmes to be available in all countries by 2005.

to the Declaration, 90% 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.

NATIONAL PREVENTION PLANS AND LEVEL OF IMPLEMENTATION

Approximately 85% of countries have national plans for the provision of HIV information, education and communications to the general population; 85% have a policy or strategy promoting reproductive and sexual health education for young people; 94% have national plans to facilitate access to key prevention commodities, such as condoms. Except for commodities access, which shows a marked increase over the 81% reported in 2003, these figures are roughly comparable to percentages reported in 2003.

It is clear, however, that national prevention plans are generally not being effectively implemented. Coverage surveys indicate that, on average, a condom was used in only an estimated 9% of sex acts with a non-marital and non co-habitating partner globally in 2005—a decline over coverage estimates for 2003. Only an estimated 0.6% of adults in low- and middle-income countries learned their HIV serostatus in 2005, with especially low testing rates reported in East Asia and the Pacific (0.1%), South-East Asia (0.1%), and North Africa and the Middle East (0.2%). Testing utilization in 2005 was highest in sub-Saharan Africa (2.2%) and in Latin America (2.1%).

PREVENTING MOTHER-TO-CHILD HIV TRANSMISSION

While access to combination antiretroviral therapy increased more than three-fold between 2003 and 2005, the world made only modest progress in expanding access to programmes to prevent mother-to-child transmission (Figure 3.2). In 2005, 9% of pregnant women in low- and middle-income countries were offered services to prevent transmission to their newborns—a modest increase over the 7.6% coverage in 2003. Between 2003 and 2005, the percentage of HIV-positive pregnant women who received prophylactic antiretrovirals increased from 3.3% to 9.2%.

Data suggest that the recent commitment to scale up antiretroviral treatment
CIVIL SOCIETY PERSPECTIVES

The 2005 UNGASS reporting round is the first to include independent civil society reports on the progress made in national responses to HIV and the Declaration of Commitment on HIV/AIDS. UNAIDS received reports from civil society informants in 33 countries, including 11 from Latin America and the Caribbean, 6 from Asia and the Pacific, 8 from sub-Saharan Africa, 4 from Eastern Europe and Central Asia, and 4 from North America and Western and Central Europe.

These reports emphasize the central role of civil society in designing and implementing innovative and effective national responses, and in promoting change within communities to address stigma and discrimination and to accelerate community awareness and mobilization. In Senegal, for example, five nongovernmental organizations recently launched the Observatoire de la réponse au VIH/SIDA to serve as a “watchdog” to increase HIV awareness and highlight weaknesses in national HIV prevention and care efforts. While most reports highlighted the value of civil society engagement in the national response, several called for much broader involvement, including at the district and local levels, where engagement of civil society is often less prominent than in national forums.

Several civil society groups cited the need to improve coordination between national AIDS efforts and civil society activities. The civil society report on Nicaragua, for example, said that nongovernmental organizations, academic researchers, health workers and government agencies often work in isolation from each other. In the United States, civil society informants said decentralized decision-making promotes greater responsiveness to local needs but puts higher demands on coordination, accountability and equity.

Civil society reports indicated that important progress has been made in many countries in expanding HIV prevention and treatment services; important gaps remain, however. In Haiti, civil society reports indicate that services are badly needed for children orphaned or made vulnerable by AIDS and for key at-risk populations, such as the poor (especially women), sex workers and men who have sex with men. Several reports indicate that treatment access is often minimal in rural areas. According to civil society informants from Tanzania, the absence of a clear national policy on HIV/Tuberculosis co-infection has led to inadequate integration of HIV and tuberculosis services, while civil society reports indicate that Thailand has made great strides since 2001 in integrating them.

Awareness of the Declaration of Commitment on HIV/AIDS is often limited among civil society organizations. In several countries, civil society groups perceived that the national AIDS response is primarily donor-led, often leaving civil society organizations out of the decision-making process. In many countries, civil society groups were involved in national efforts to report on core indicators pertaining to the Declaration of Commitment on HIV/AIDS, while integration of civil society into national reporting was limited or non-existent in other countries. All civil society reports said improvement is needed in national capacity for AIDS monitoring and evaluation.
programmes has not translated into renewed commitment to bring proven prevention strategies to scale. In three sub-Saharan African countries—Kenya, Namibia and Uganda—in which 2003 and 2005 data were reported for both antiretroviral treatment for advanced HIV infection and prevention of mother-to-child transmission, the pace of increase in treatment coverage notably outweighed comparable increases in coverage for prevention services in antenal settings (Figure 3.3). In Uganda, for example, antiretroviral coverage increased from 6.3% in 2003 to 56.0% in 2005—a nearly ten-fold increase—while service coverage for prevention of mother-to-child transmission rose from 4.6% to 12%. Integration of prevention and treatment services represents a pressing priority to increase uptake of both antiretroviral treatment and prevention of mother-to-child transmission.

**INCREASING KNOWLEDGE AND AWARENESS**

Most countries appear to have missed the Declaration of Commitment on HIV/AIDS' target of ensuring that 90% of young people in 2005 receive critical prevention interventions, including services to develop the life-skills needed to reduce vulnerability to HIV. Among
15 countries with data available from the last two years—10 of them in sub-Saharan Africa—only three (Dominica, Malawi and Swaziland) achieved at least 90% coverage of schools with properly trained teachers who provided life-skills-based HIV education. Five countries surveyed—Côte d’Ivoire, Honduras, Nigeria, Saint Lucia, and Togo—showed slow progress in HIV education coverage, with less than 20% coverage of schools in 2005. The very low number of countries reporting on this indicator, which was even lower than in 2003, highlight the need for improved monitoring. Failure to report, however, does not necessarily indicate the absence of progress. Preliminary data from coverage surveys undertaken by the Policy Project in 2005 points towards an increase between 2003 and 2005 in the number of countries providing AIDS education in primary schools, although no increase was reported for secondary schools (Stover et al., 2006). Interpretation of such findings is challenging, as the presence of school curricula does not necessarily mean that children actually receive such instruction. At best, it appears that only about half of children attending school actually receive school-based HIV and AIDS education, under-scoring the importance of additional
progress in this facet of the AIDS response.

Far from ensuring comprehensive HIV-related knowledge among 90% of young people (ages 15–24) by 2005, none of the 18 countries in which young people were surveyed by the Demographic Health Survey/AIDS Indicator Survey between 2001 and 2005 had knowledge levels exceeding 50% (Measure DHS, 2006). In all but three countries in which data are available for both males and females, young men had higher levels of HIV-related knowledge than young women. The variation in comprehensive HIV knowledge between countries is noteworthy; among young women in the 14 sub-Saharan African countries surveyed, comprehensive knowledge levels ranged from below 10% in Benin, Chad and Mali to more than 40% in Botswana and Tanzania.

Data suggest that school-based HIV education is critical to increasing HIV-related knowledge levels for young people (Measure DHS, 2006). Generally, HIV-related knowledge levels seemed to double for young people who had received at least a primary education, and rates seemed to quadruple among young people with secondary education or higher (Figure 3.4 for young men, Figure 3.5 for young women).

Surveys of sexual behaviour pose many challenges, especially with respect to young people, who may give in to social pressure to respond in ways that may result in under- or over-reporting of actual sexual activity. Even accounting for reporting bias, such surveys reveal enlightening aggregate trends. The most recent surveys underscore that many young people continue to engage in behaviours that place them at risk of HIV infection, although some encouraging trends are also detectable.

**DELAYING SEX**

Delaying the age at which young people initiate sex is an important aim of HIV prevention efforts. Among 15 countries in sub-Saharan Africa surveyed by the Demographic and Health Survey/AIDS Indicator Survey (MEASURE DHS, 2006), the percentage of young men aged 15–19 who report having had sexual intercourse before the age of 15 ranged from 2.1% in Mauritania to 30.9% in

---

**Figure 3.4**

Comprehensive knowledge about HIV and AIDS among young males aged 15–24, by level of education, in 11 sub-Saharan African countries, 2000–2004

[Bar chart showing comprehensive knowledge levels among young males in 11 sub-Saharan African countries by level of education (2000–2004).]

Kenya, while figures for young women aged 15–19 ranged from 7.3% in Burkina Faso to 27.7% in Mozambique. Comparable variations are evident outside Africa and from additional surveys, with the percentage of males aged 15–19 having sex prior to the age of 15 ranging from 0.3% in Viet Nam to 46% in urban areas of Moldova. In an encouraging trend, the percentage of young people who initiated sex prior to age 15 declined overall or partially (i.e. either among women only or men only) in nine of the 14 sub-Saharan African countries for which trend data are available.

REDUCING THE NUMBER OF SEXUAL PARTNERS

Trends are somewhat more mixed with respect to the percentage of young people (aged 15–24) who have had sex with a non-marital, non-cohabitating partner in the last 12 months. As in the case of sexual debut, there are marked variations among national populations of young people. Recent Demographic Health Surveys/AIDS Indicator Surveys among 13 sub-Saharan African countries showed that rates among young women vary from 7% (Chad) to 50% (Ghana) and among young men from 72% (Madagascar) to 91% (Cameroon). Comparable variations are visible in the Latin America and Caribbean region (10–31% for young women and 70–83% for young men) (Measure DHS, 2006). The occurrence of intercourse with non-regular partners is sharply lower in Asia, although here, too, rates are at least twice as high for males as for females. Among eight countries that have repeated behavioural surveys among young people, three reported little or no change over time in the percentage of young people having sex with non-marital, non-cohabitating partners, three reported an increase and two detected a decline. The indicator only captures changes if young people stop having sex with any non-regular partner, not if they reduce the frequency of sex with such partners, although the latter can also have a significant impact on the spread of the epidemic.

USE OF CONDOMS

For young people who are sexually active, consistent condom use is a critical HIV prevention measure. Demographic and Health Surveys/AIDS Indicator Surveys conducted between 2001 and 2005 indicate that young men are more likely than young women to report
condom use with a non-regular partner (Measure DHS, 2006). Among 20 sub-Saharan countries for which survey data are available, the percentage of young people who use a condom with non-regular partners ranges from 5% of females and 12% of males in Madagascar, to 75% of females and 88% of males in Botswana (Figure 3.6). Among 11 sub-Saharan African countries that have conducted repeated surveys, condom use among young people increased in eight countries, although rates of condom use remain below 50% in most countries. In all but one national survey, fewer females than males reported condom use during intercourse with a non-regular partner.

TREATING SEXUALLY TRANSMITTED INFECTIONS

Precise information on service coverage of treatment services for sexually transmitted infections is extremely scarce. In 2001, WHO estimated that fewer than 18% of people with a sexually transmitted infection had access to treatment services. For purposes of monitoring the Declaration of Commitment on HIV/AIDS, only 12 countries submitted reports on services for sexually transmitted infections in 2005, making it difficult to gauge global or regional coverage with any accuracy. In 2005, however, WHO and Germany’s Agency for Technical Cooperation (GTZ) reported that access to

---

**Figure 3.6** Percentage of young people aged 15–24 reporting the use of a condom during sexual intercourse with a non-regular partner, Sub-Saharan Africa, 2001–2005

<table>
<thead>
<tr>
<th>Country (Year)</th>
<th>Female</th>
<th>Male</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benin 2001</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Botswana 2001</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Burkina Faso 2003</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cameroon 2004</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chad 2004</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ghana 2003</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Guinea 2005</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kenya 2003</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lesotho 2004</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Madagascar 2003</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Malawi 2004</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mali 2001</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mozambique 2003</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nigeria 2003</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rwanda 2004</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Senegal 2005</td>
<td></td>
<td></td>
</tr>
<tr>
<td>United Republic of Tanzania 2003</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Uganda 2004</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Zambia 2003</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

treatment for sexually transmitted infections is especially limited in sub-Saharan Africa (Dehne and Riedner, 2005).

**PROTECTING THE BLOOD SUPPLY**

Countries have made notable progress in improving the safety of national blood supplies, with nearly 100% of countries reporting that blood is now routinely screened for HIV antibodies. Unsafe blood transfusions accounted for an estimated 5–10% of infections in the 1980s and early 1990s, leading to the introduction of standard blood safety interventions, with a particular focus on HIV screening of donated blood. However, available information suggests that national blood screening efforts are often impeded by inadequate quality assurance mechanisms, poor staff training and suboptimal laboratory procedures, which can cast doubt on the reliability of test results.

**DECREASING PREVALENCE OF HIV**

Information is limited on global success in achieving the Declaration of Commitment on HIV/AIDS' 2005 target of a 25% reduction in HIV prevalence among young people (aged 15–24). Analysis of trends in HIV prevalence among 15–24-year-old pregnant women in capital cities is limited to a small number of countries. Among countries with generalized epidemics, 33 had reported relevant data for at least one year between 2000 and 2005. Of the 11 countries that provided data for both 2000/2001 and 2004/2005, six countries showed a 25% or more decline in prevalence between 2001 and 2005. These are Angola, Burkina Faso, Burundi, Ethiopia, Uganda and Zimbabwe. However, in Angola, Ethiopia, and Burkina Faso the declines are limited to capital cities and have not been observed in the rest of the country. Additionally, declining HIV prevalence trends across all ages have been observed in a number of countries including the Bahamas, Rwanda, and Kenya, but specific data on the 15–24-year-age group was not reported.

**Care, support and treatment**

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.

Since the 2001 Special Session, the number of people in low- and middle-income countries on antiretroviral drugs increased five-fold, reaching 1.3 million in December 2005. According to WHO, the number of treatment sites providing antiretroviral drugs increased from roughly 500 in June 2004 to more than 5000 by the end of 2005. By the end of 2005, 21 countries met the “3 by 5” target of providing treatment to at least half of those who need it. WHO estimates that expanded treatment access averted 250 000 to 300 000 AIDS deaths between 2003 and 2005 (WHO/UNAIDS, 2006).

The Latin America and Caribbean region has the highest treatment coverage, delivering antiretroviral drugs to 68% of the 465 000 people who need treatment. Sub-Saharan Africa, which accounts for 72% of all people who need treatment, antiretroviral coverage reached 17% in 2005. Treatment access is most limited in North Africa and the Middle East, where only 5% of the 75 000 people needing treatment were receiving it as of December 2005. Globally, one in five people
The Declaration of Commitment on HIV/AIDS emphasizes the central importance of human rights and fundamental freedoms to an effective AIDS response.

who need antiretroviral drugs are currently receiving them.

Antiretroviral coverage varies considerably within regions. In sub-Saharan Africa, treatment coverage ranges from 3% in the Central African Republic to 85% coverage in Botswana. While more than 80% of people who need antiretroviral drugs in Argentina, Brazil and Venezuela receive such therapies, antiretroviral coverage is only 29% in Paraguay and 37% in Bolivia. In Central America, antiretroviral coverage ranges from 16% in Nicaragua to 97% in Panama and 80% in Costa Rica.

In heavily populated countries where HIV has emerged as a major problem in the last several years, the picture is mixed. In China, 25% of those needing antiretroviral drugs were receiving them in 2005. By contrast, India, which may soon have the world’s largest population of people living with HIV, antiretroviral coverage was only 7% in 2005. In the Russian Federation, only 5% of people needing treatment currently receive combination antiretroviral therapy (WHO/UNAIDS, 2006).

In 2003, only three of the 49 most heavily affected countries had national treatment plans. By December 2005, 46 countries had national plans in place for antiretroviral treatment. Between 2003 and 2005, the number of countries with national treatment targets increased from four to 40. Most countries followed WHO guidelines for treatment scale-up as the template for their national plans, identifying standard first- and second-line antiretroviral regimens for delivery through the public sector.

**HIV and human rights**

The Declaration of Commitment on HIV/AIDS emphasizes the central importance of human rights and fundamental freedoms to an effective AIDS response. Its calls on countries to enact legislation barring discrimination against people living with HIV and against vulnerable populations. It also commits countries to implementing national strategies to promote women’s rights and empower women to protect themselves from HIV infection.
Of the 115 country reports submitted to UNAIDS on core indicators, only seven made no mention of human rights. Based on country reports, some positive improvement is detectable in national human rights frameworks between 2003 and 2005. In 18 of 21 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 to promote and protect human rights. Overall, 61% of countries report the existence of laws and regulations to protect people living with HIV from discrimination. Many reports indicate, however, that many relevant national laws have not been fully implemented or rigorously enforced, and there is often a lack of strong budget allocations for human rights monitoring; 59% of countries report the existence of policies prohibiting routine HIV screening for employment.

Two-thirds (66%) of countries have no laws or regulations that specifically protect the most at-risk groups from discrimination. Almost half (45%) of countries submitting data to UNAIDS report existing laws that may hinder the delivery of HIV prevention and treatment services to vulnerable and most-at-risk populations. Examples include laws criminalizing consensual sex between males, prohibiting condom and needle access for prisoners, and using residency status to restrict access to prevention and treatment services. Countries reporting the existence of such laws include both high-income and low-income countries. Countries in Asia (70%) and the Caribbean (83%) are most likely to report having laws that may impede the delivery of services to vulnerable populations.

The greater majority (82%) of countries have national strategies to ensure equal access by women and men to prevention and care. The major challenge in many countries with respect to reducing vulnerability and ensuring equitable access for women appears to concern effective implementation and enforcement of existing laws and policies as well as societal and economic barriers. Morocco, for example, reports that women’s lower literacy rates may impede their utilization of services. Uganda reports that women are less likely to have financial resources than men, potentially diminishing their access to HIV services.

Reducing vulnerability among most-at-risk populations

Recognizing that poverty, social marginalization, gender inequality and discrimination create conditions that increase vulnerability to HIV, the Declaration of Commitment on HIV/AIDS provides for countries to 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 indicate that national efforts are not sufficiently prioritizing the delivery of essential, life-preserving interventions to those at greatest risk.
According to the country reports, men who have sex with men and injecting drug users have lower coverage rates of prevention programmes than sex workers, even in countries that are reported to address such components in their national policy or strategy (Figure 3.7). Such programmes comprise, among other activities, community outreach programmes that include peer education, targeted mass media campaigns, sexually transmitted infection screening and/or treatment, HIV counselling and testing; substitution therapy and safer injection practices for injecting drug users.

Globally, targeted prevention services within community outreach programmes reached 36% of sex workers in 2005, which ranged from 8% in Eastern Europe, 22.5% in sub-Saharan Africa, 35% in Latin America and the Caribbean, to 39% in South East Asia (Stover et al, 2006).

Prevention coverage is even more limited for men who have sex with men. Globally, on average only 9% of men who have sex with men received targeted prevention services or outreach programmes, with Latin America and the Caribbean having the highest prevention coverage at 22%, with minimal coverage in Eastern Europe and Central Asia at 1%, 5% in North Africa and Middle East, and 8% in East Asia and the Pacific (Stover et al., 2006).

Even though injecting drug use accounts for a significant portion of new infections outside sub-Saharan Africa, only a small fraction of people who use injecting drugs received harm-reduction services in 2005. Harm-reduction programmes in 2005 reached only 9% of injecting drug users in Eastern Europe, where injecting drug use is driving the epidemic’s expansion.

At the other end of the scale, there are indications that injecting drug users are not equitably benefiting from the global expansion in treatment access. WHO estimated that Brazil alone accounted for 30 000 of the 36 000 injecting drug users who were receiving antiretroviral drugs at the end of 2004 (WHO/UNAIDS, 2005). Although people who inject drugs account for more than 70% of HIV cases in Eastern Europe and Central Asia, they represented only 24% of people receiving
THE AIDS RESPONSE IN HIGH-INCOME COUNTRIES

As of March 2006, 15 high-income countries (Annex 3) had reported on their progress towards the implementation of the Declaration of Commitment on HIV/AIDS. Most high-income countries have relatively strong HIV and AIDS surveillance systems, but many lack a nationally coordinated monitoring system to aggregate diverse data sets, such as behavioural risk assessments and coverage for key services. While donors support behavioural data gathering in developing countries, routine monitoring of sexual and drug-using practices are often not formally established in high-income countries. Even when civil society organizations collect such information, national governments may be unaware of such efforts or may not recognize such information as official.

In general, HIV prevalence is increasing in high-income countries. This stems from a variety of factors, including continued transmission of HIV, combined with reduced HIV-related morbidity and mortality as a result of antiretroviral therapy, as well as ongoing migration to high-income countries from low-income countries, where HIV prevalence is generally higher. In some high-income countries, there is evidence that sexual risk behaviours have increased in some populations in recent years.

The failure of many industrialized countries to submit data relevant to the core indicators for the Declaration of Commitment on HIV/AIDS may suggest that many professionals and policy-makers regard such reporting as relevant only for low- and middle-income countries. Because AIDS is a global problem, however, trends in developing countries may also have an impact on high-income countries. In the United Kingdom, for example, recent years have witnessed a substantial increase in the number of people living there who were infected in Africa (UK Collaborative Group for HIV and STI Surveillance, 2005).


Children orphaned and made vulnerable by AIDS

To mitigate the epidemic’s impact on children, the Declaration of Commitment on HIV/AIDS calls on countries to implement national strategies to support children orphaned and made vulnerable by AIDS, to ensure their equal access to education and other services, and to protect them from abuse and stigmatization.

Globally, only half of countries have a policy to address the needs of children orphaned or made vulnerable by the epidemic. In sub-Saharan Africa, 25 of 29 countries reported that they have national policies in place to address the additional HIV- and AIDS-related needs of orphans and other vulnerable children. Overall, 49% of countries say they are doing an average or below-average job of addressing the needs of children orphaned or made vulnerable by AIDS, including 10 countries in sub-Saharan Africa, where the needs of such children are most pressing.
Among the 25 countries in sub-Saharan Africa with national policies, 21 reported having reduced or eliminated school fees for vulnerable children and having implemented community-based programmes to support orphans and other vulnerable children. Nevertheless, children orphaned by AIDS lag behind non-orphans in rates of school attendance, with 62% of children orphaned by AIDS in Africa attending school in 2005, compared to 70% of non-orphans (UNICEF, 2006). Outreach services made contact with only 19.5% of children living on the streets in 2003. Globally, UNAIDS estimates that less than 10% of children orphaned or made vulnerable by AIDS are receiving external support of any kind (UNICEF, 2005).

Research and development

The Declaration of Commitment on HIV/AIDS urges strong and sustained research efforts to strengthen the search for a preventive vaccine and other new prevention technologies. It also provides that all research protocols involving human subjects should be evaluated by an ethical review committee.

It is likely to be a decade or more before a preventive HIV vaccine is available for use. Progress to date has been slow in vaccine research and development, due to a host of logistical and scientific challenges. In 2004, public, philanthropic and commercial sectors invested an estimated US$ 682 million in HIV vaccine research and development.

Since the 2001 Special Session, momentum has increased in the field of research and development on vaginal microbicides to prevent HIV transmission. Investment by public and philanthropic sectors in microbicide research and development has more than doubled, increasing from US$ 65 million in 2001 to an estimated US$ 163 million in 2005.

Almost three-quarters (73%) of countries report having a policy requiring approval by an ethics review committee of all research protocols involving human subjects. This reflects the status quo compared to 2003. With respect to inclusion of people living with HIV and their caregivers in the ethical review of research protocols, 71% rate national efforts as average or below-average (scoring 0 on a scale of 0–10).

HIV in conflict and disaster-affected regions

Acknowledging the potential for conflicts and disasters to increase vulnerability and contribute to the spread of HIV, the Declaration of Commitment on HIV/AIDS calls on countries to integrate HIV activities into programmes and action plans for emergency situations. It also provides for international and nongovernmental organizations to invest in HIV awareness and training for personnel and for HIV to be incorporated into operations of national uniformed services and international peacekeepers.

According to UNHCR, only 65% of national strategic plans in 2004 mentioned refugees and only 43% articulated specific refugee-related activities (UNAIDS/UNHCR, 2005). In 2005, 86% of countries had a formal strategy for addressing HIV among uniformed services, compared to 78% in 2003.

In contrast, the UNAIDS Secretariat and the UN Department of Peacekeeping Operations have fully integrated into
UN-sanctioned peacekeeping operations. Currently, all peacekeeping missions benefit from full- or part-time HIV advisers.

Resources

The Declaration of Commitment on HIV/AIDS urged a steady scaling-up of global HIV financing to ensure the annual mobilization by 2005 of at least US$ 7 billion to US$ 10 billion (United Nations, 2001). To spur resource mobilization, it called for the creation of a global fund to support the delivery of HIV and other health interventions. It further provided for national governments to increase budgetary allocations for HIV and for developed countries to strive to dedicate at least 0.7% of gross national product to development assistance.

Overall resource mobilization is one of the few hard targets for 2005 from the Declaration of Commitment on HIV/AIDS that the global community clearly achieved. On the basis of current trends in pledges and funding commitments, UNAIDS projected that HIV spending, from national and international sources, in low- and middle-income countries in 2005 would amount to US$ 8.3 billion (range estimate between US$ 7.5 billion and US$ 8.5 billion), within the US$ 7–10 billion range targeted in the Declaration of Commitment on HIV/AIDS (see ‘Financing’ chapter).

While the global success in achieving the resource mobilization target is heartening, more extensive analysis subsequent to the 2001 Special Session indicates that substantially greater resources will be required to place the world on track to begin to reverse the HIV epidemic by 2015. HIV funds available in 2005 are barely one-third of the amount that will be needed in 2008 (US$ 22.1 billion) to support a comprehensive response (UNAIDS, 2005c).

The average annual increase in global HIV spending rose from US$ 266 million yearly between 1996 and 2001 to US$ 1.7 billion yearly between 2001 and 2005. Estimates of resources available for HIV activities in low- and middle-income countries in 2005 represent a 28-fold increase over global HIV spending in 1996, when UNAIDS was created (Figure 3.8).

**Figure 3.8**

Estimated total annual resources available for AIDS, 1996–2005

- Data include:
  - International donors, domestic spending (including public spending and out-of-pocket expenditures)
  - International Foundations and Global Fund included from 2003 onwards, PEPFAR included from 2004 onwards

*Projections based on previous pledges and commitments (range of the estimation: US$ 7.5 to US$ 8.5 billion).
Based on reports to the Organisation for Economic Co-operation and Development from donor countries, between 2001 and 2004, the level of bilateral financing for HIV activities increased by 61%, while spending from multilateral sources (e.g. Global Fund to Fight AIDS, Tuberculosis and Malaria, organizations in the UNAIDS family, regional development banks and the European Commission) increased by 110%. The rate at which donor-committed funds were actually disbursed increased from 53% in 2002 to 78% in 2004 (Organisation for Economic Co-operation and Development, 2006). Currently, the United States Government accounts for roughly half of all bilateral commitments for HIV.

As explained in greater detail in the ‘Financing’ chapter, the Global Fund has played an important role in channelling new resources for HIV since the 2001 Special Session. As provided for in the Declaration of Commitment on HIV/AIDS, the Global Fund was launched in December 2002. It is estimated that roughly 20% of all international financial flows for HIV is currently channelled through the Global Fund. As of December 2005, the Global Fund had received US$ 8.6 billion in pledges (through 2008) and had approved 350 grants to governments and other recipients in 128 countries, thus committing US$ 4.79 billion of these grants; US$ 3.5 billion has been obligated through the signing of the grant agreements; and US$ 1.91 billion has been disbursed. Out of these funds, between 56% and 60% would be for HIV. Thus the adjusted subtotals for HIV activities would be US$ 2.96 billion for approved projects; US$ 2.14 billion obligated and US$ 1.2 billion disbursed (Global Fund, 2006).

The world confronts significant additional challenges in translating these globally available financial resources into goods and services for those who need them. In particular, available funds are often not directed to those in greatest need. In many countries, programmed resources remain concentrated in the bigger cities and often target those who are most easily accessible rather than those who most need the services. In Latin America and South-East Asia, for example, while men who have sex with men represent a substantial part of the epidemic, they receive only a tiny fraction of prevention resources (Izazola-Licea, 2003). Similarly, sex workers in sub-Saharan Africa benefit from a disproportionately small share of available resources.

Low- and middle-income countries themselves are providing roughly one-third of current global spending on HIV activities, with public sector spending in such countries showing a modest increase between 2001 and 2005. Public sources account for the bulk of domestic HIV expenditures, although a substantial portion of such spending derives from out-of-pocket outlays by HIV-affected households, to provide needed care and treatment, or in some cases even the purchasing of condoms by middle class populations in middle-income countries (UNAIDS, 2004) (Gutierrez and Bertozzi, 2004) (Aran-Mantero et al., 2003).

Since the 2001 Special Session, there has been a modest increase in per capita spending on HIV by developing countries overall (Figure 3.9). In a sample of 25 low-income sub-Saharan African countries, by contrast, per capita spending increased 130% between 2001 and 2005, amounting in 2005 to total spending of US$ 670 million in these countries. Per
capita, domestic public sector spending on AIDS in the same sample in sub-Saharan Africa rose from US$ 0.31 in 2001 to an estimated US$ 0.65 in 2005. Domestic spending on HIV in sub-Saharan Africa does not closely correlate with national HIV prevalence, national income or national health expenditures.

Per capita spending on AIDS in other regions is generally higher than in sub-Saharan Africa (n = 57 countries). Among low-income countries outside sub-Saharan Africa (gross national income per capita of US$ 825 or less), per capita AIDS expenditures remained almost unchanged between 2001 and 2004 (oscillating between US$ 0.35 to US$ 1.00). Among lower-middle-income countries (gross national income per capita of US$ 826–US$ 3255) there was an increase of around 30% from 2001 to 2005. Among the upper-middle-income countries (gross national income per capita of US$ 3256–US$ 10 065) there was an increase of around 10% in the same time frame.

Improvement is needed in countries’ capacity to disaggregate donor assistance from national sources, to distinguish between budgeted amounts and actual expenditures, and to generate reliable estimates of total expenditures from all sectors (UNAIDS, 2006). The Global Resource Tracking Consortium has worked to supplement information from country reports with National AIDS Spending Assessments, a resource tracking exercise that has enhanced the reliability of estimates of gaps between available resources and actual resource needs.

Monitoring and evaluation

An accurate understanding of both the epidemic and the national response is critical to the development, implementation and improvement of sound national AIDS policies and programmes. Both
developing countries and international donors have placed greater priority on monitoring and evaluation since the 2001 Special Session, and 51% of countries report modest to considerable progress since 2003 in strengthening monitoring and evaluation of HIV-related programmes. Nevertheless, 43% of countries rated national monitoring and evaluation efforts as average or below average. It was often the countries with dedicated monitoring and evaluation officers that reported improvement of monitoring systems at the national level. In addition, over 60 monitoring and evaluation technical advisors were deployed in countries by UNAIDS and the United States Government to assist with national monitoring and evaluation capacity-building, and planning and reporting needs (CDC/GAP, 2005).

Half of countries report the existence of a national monitoring and evaluation plan, up from 43% in 2003. In just over half (54%) of the cases, the monitoring and evaluation plan was developed in consultation with civil society and people living with HIV. All but four of these countries have a dedicated budget for monitoring and evaluation, with funding secured in 78% of the cases. This represents important progress since 2003, when only 24% of countries reported having a monitoring and evaluation budget. The majority (83%) of countries have a dedicated monitoring and evaluation unit and/or a committee that meets regularly, and 11 countries are in the process of establishing such a unit.

Concerning information, 54% of countries have a central database for HIV-related information and 85% maintain a functional Health Management Information System, with half of these countries having both systems in place. These figures are roughly equivalent to those reported in 2003. While the existence of data management systems does not necessarily signify the routine use of such technology, countries that have a centralized database report the most extensive use of data in national planning and programme implementation. Over 70 countries used the UNAIDS Country Response Information System to collect and report their relevant indicators to UNAIDS and over 90 countries now use this system for additional purposes.

About half (49%) of countries indicate that there is a moderate to high level of sharing with the national government of monitoring and evaluation results by UN agencies, bilateral agencies and other institutions. Although this represents improvement, substantial further strides are needed with respect to data-sharing in order to maximize evidence-based decision-making and support strengthening the principles of the “Three Ones,” especially the third: one unified monitoring and evaluation system.

As Figure 3.10 illustrates, the first principle (a single national authority) and second principle (a single national framework) of the “Three Ones” have been largely achieved. Success now depends on increasing national monitoring and evaluation capacity to support a unified monitoring and evaluation system. As shown in Figure 3.10, only 50% of countries have a monitoring and evaluation plan, which is the first critical step fostering the development of a unified system.

Country reporting on the core indicators for the Declaration of Commitment on HIV/AIDS provides insights into the current status of monitoring and evaluation
capacity, as well as guideposts for future efforts to increase national capacity in this field. While indicators pertaining to antiretroviral treatment and the prophylactic administration of antiretroviral drugs to prevent mother-to-child transmission were relatively well-reported, substantially less comprehensive information was reported regarding survival at 12 months following initiation of antiretroviral therapy. Management of sexually transmitted infections was also poorly reported, although this may stem in part from the complexity of the indicator, which requests information on correct diagnosis, provision of counselling and completeness of treatment. The least frequently reported indicators pertained to children orphaned by AIDS; fewer than 10 countries reported on those indicators. This has implications for how well countries can assess the need for and implementation of services designed to help this highly vulnerable population.

Overall, countries with generalized epidemics provided more complete reports than those with concentrated or low-prevalence epidemics. Although not a requirement for countries with a generalized epidemic, 31% reported on indicators for most-at-risk populations.

Although important progress has been made in building national capacities for monitoring and evaluation, gaps in national reporting underscore the need for considerable further improvement.
Less than two-thirds (60%) of the countries with concentrated or low epidemics reported on most-at-risk populations. This is the first time that specific information was reported by countries on their most-at-risk-populations, and although there is considerable room for improvement, it does form a solid basis to monitor further progress.

Although important progress has been made in building national capacities for monitoring and evaluation, gaps in national reporting underscore the need for considerable further improvement. Areas of needed improvement include expanding the number and types of programmes and services to be monitored, the collection of more robust and timely information, and improving analytic use of such data by policy-makers and service providers for programme improvement. In addition, increased emphasis on evaluation, so far virtually ignored in most countries, needs to be an immediate priority. These evaluation activities are essential next steps for improving the effectiveness of the AIDS response. In most countries, implementing such improvements will require additional human and financial resources for monitoring and evaluation, as well as better integration of information from a variety of sources. Ultimately, increased ownership of the monitoring and evaluation process by countries is required, as well as increased willingness to act on findings to improve the national AIDS response and thereby contribute to the global response.